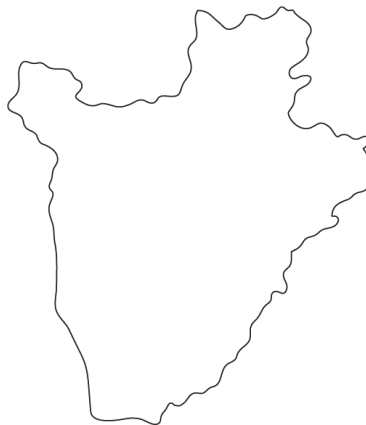




**How the “Joint Program” Intervention Should or Might Improve Adolescent Pregnancy in Burundi, How These Potential Effects Could Be Encouraged, and Where Caution Should Be Given.**



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## Introduction

Adolescent pregnancy, defined as pregnancy in girls aged 10-19 years (WHO, 2004), often causes girls to suffer a number of social, economic, and health consequences. Recurrently, their education is interrupted or ended, they lose the ability to enter into the labour workforce successfully, they may be forced to marry either the father of their child or another man, they suffer social stigmas, and they have higher risks of experiencing complications during and after their pregnancy which may lead to permanent or chronic conditions. Adolescent pregnancy rates are highest in many low and low-middle income countries, such as those found in the Great Lakes region in East Africa. Here, the percentage of adolescent girls aged 15-19 who have begun childbearing are 12.5% in Ethiopia (Central Statistical Agency/CSA/Ethiopia and ICF 2016), 18.1% in Kenya (Kenya National Bureau of Statistics *et al* 2015), 7.3% in Rwanda (National Institute of Statistics of Rwanda *et al* 2015), 24.8% in Tanzania (Ministry of Health, Community Development, Gender, Elderly and Children *et al* 2016), 24.8% in Uganda (Uganda Bureau of Statistics and ICF. 2018), and with the highest rate of 27.2% in the Democratic Republic of Congo (Ministère du Plan et Suivi de la Mise en œuvre de la Révolution de la Modernité *et al* 2014). In Burundi, 8.3% of girls aged 15-19 have begun childbearing (Ministère à la Présidence chargé de la Bonne Gouvernance et du Plan Burundi 2017). Although Burundi is on the lower end of these countries, 8.3% is still worrying. Furthermore, unlike countries such as Kenya, Ethiopia, and Uganda, adolescent pregnancy in Burundi is strikingly understudied. Moreover, in June 2018 the Ministry of Education announced a “blanket” ban on pregnant girls and expecting fathers attending school, a ban that was retracted a month later (Bhalla 2018). This ban would have only worsened the prospects of pregnant girls. Such lack of attention to Burundi partnered with unsatisfactory institutional attitudes towards adolescent pregnancy only highlight the need for greater attention, care, and empathy in confronting the problem of adolescent pregnancy in Burundi.

This paper has been commissioned by Share-Net International for these purposes. Share-Net International is the knowledge platform on sexual and

reproductive health and rights (SRHR) organised in four country hubs in Bangladesh, Burundi, Jordan, and the Netherlands (Share-Net International n.d.). The focus of Share-Net Burundi is to identify best strategies to prevent and reduce adolescent pregnancy. In line with this focus, this paper explores the Joint Program called "Menyumenyeshe" to Enhance Sexual and Reproductive Health of Adolescents and Young People of 10-24 Years in Burundi (here forth referred to as the “Joint Program”) in the context of adolescent pregnancy in Burundi and interventions to prevent and reduce adolescent pregnancy in other low and low-middle income countries. Although adolescent pregnancy is not an outcome measure of the Joint Program, all seven outcome indicators used for the intervention are proximate factors to adolescent pregnancy. The specific aim of this paper is therefore to evaluate how the Joint Program *should* or *might* have desirable effects on adolescent pregnancy in Burundi and how these potential effects could be encouraged further in future related or similar interventions.

To this end, first adolescent pregnancy is contextualised in Burundi by exploring what is and is not known and also by summarising known information on proximate factors regarding sexual and reproductive health (SRH) knowledge, attitudes, and practices. Secondly, the Joint Program is summarised and thereafter discussed in comparison with existing literature on adolescent pregnancy interventions from low and low-middle income countries. This research has been carried out predominantly through reference to academic articles and reports commissioned by organisations such as the UNFPA and WHO. However, it does also make reference to online news articles that provided information and statistics unavailable in peer reviewed literature or NGO reports.

## Contextualising Adolescent Pregnancy in Burundi

Adolescent pregnancy can be defined as pregnancy in girls aged 10-19 years (WHO 2004). Around 16 million girls aged 15-19 and 2 million girls under 15 become pregnant every year (UNFPA 2015). 11% of births worldwide follow adolescent pregnancies and 95% of these occur in developing countries (WHO 2011). Adolescent pregnancy is caused by a range of cultural, social, and economic

factors that vary across geographical locations. Around 23 million girls living in developing countries do not have access to modern contraception (WHO 2018). By providing adequate access 2.1 million unplanned births, 3.2 million abortions, and 5,600 maternal deaths could be avoided annually (Darroch *et al* 2016). 90% of adolescent pregnancies across the globe occur within marriage (Psaki 2015) as this increases the pressure to have children (Acharya *et al* 2010; Presler-Marshall and Jones 2012; UNICEF 2013) and reduces a girl's ability to negotiate safe sex practices with their spouse (UNICEF 2013).

Despite its pressing nature, adolescent pregnancy in Burundi remains understudied (Kamwenubusa 2014). As stated, 8% of girls in Burundi experience pregnancy during their teenage years (Ministère à la Présidence chargé de la Bonne Gouvernance et du Plan Burundi 2017). In contrast to the overall association between adolescent pregnancy and child marriage, activists in Burundi state that the majority of pregnancies occur outside of marriage with forced marriages following adolescent pregnancies (Nininahazwe 2017). In 2017, it was found that 3% of girls were married by age 15 and 20% by age 18 in Burundi (UNICEF 2017). It is however unclear how these relate to adolescent pregnancy. Despite the lack of knowledge on adolescent pregnancy in Burundi, looking at proximate factors can contextualise and further inform this phenomenon.

Burundi exhibits significant shortcomings in regard to the knowledge, attitudes, and practices on SRHR of adolescents and youth. Although it was found that 83.4% of youth have sufficient knowledge of HIV and 72.8 % have some knowledge of SRH services, only 5.3% of youth have a good knowledge of all STIs (Munsero and Birgrimana 2017). The concept of SRHR is only known by 11% of secondary school students, and yet these students do not include their SRHR when considering their futures (Twungubumwe 2016). In specific regard to conception, only 49.8% of girls and 41.8% of boys understand well the period of increased risk of pregnancy during the menstrual cycle, with 27.9% of girls and boys thinking that risk is highest during menstruation (Munsero and Birgrimana 2017).

Different studies have found conflicting results regarding SRH attitudes of Burundian adolescents and youth. For example, in the baseline study of the Joint Program it was found that 65.1% of youth have favourable attitudes towards SRH services and of these 50.2% are very favourable (Munsero and Birgrimana 2017). However, Twungubumwe (2016) found that most youth expressed negative associations towards SRH services grounded in perceptions of the service providers' motivation being financially based, fear of service providers breaching medical confidentiality, perceived low motivation of service providers, and rumours about the negative effects of contraceptive methods. Furthermore, it was found that many youths believed SRH services were only for married men and women (Twungubumwe 2016). Moreover, many youth found that there was little community support for SRH services. Only 8.8% of 10-24 year olds said local leaders supported SRH services with community health workers being the most supportive and community leaders being least supportive (Munsero and Birgrimana 2017). Additionally, only 11.4% of 10-24 year olds felt familial support towards SRH services (Munsero and Birgrimana 2017). It is unclear how youth-friendly Burundian SRH services are and whether they proactively take into account the difficulties, prejudices, and barriers that adolescents and youth, wishing to use their services, might face in doing so.

SRH practices among adolescents and youth in Burundi are particularly striking. Between 2009 and 2012 there were 4760 pregnancies among school girls. Additionally, 11% of adolescent girls aged 15-19 are sexually active (UNFPA 2016). By 2016, 8.3% of adolescent girls aged 15-19 years had already begun childbearing (Ministère à la Présidence chargé de la Bonne Gouvernance et du Plan Burundi 2017). Furthermore, only 17.5% of youth used a condom during their last intercourse, and this was 4 times higher for boys than for girls (Munsero and Birgrimana 2017). Girls are therefore disproportionately exposed to risks of early pregnancy or STI contraction by lack of condom use. Lastly, only 4.8% adolescents reported ever having used SRH services once (Twungubumwe 2016), which is significantly worrying.

To address the multiple challenges in the field of SRHR that Burundian youth face, the Government of Burundi has started to place more emphasis on improving adolescent and youth overall health through various Health Policy and Strategy documents (Batungwanayo, Mpinganzima and Bizozo 2019).

In 2015 a "Multisector National Strategy for Adolescent and Youth Health in Burundi 2016-2020" was developed. As part of this strategy, the Netherlands Embassy in Burundi funded the Joint Program to support adolescent and youth sexual and reproductive health in Burundi (Batungwanayo, Mpinganzima and Bizozo 2019).

### **The "Joint Program"**

The Joint Program was launched in 2015 by the government of Burundi in partnership with Care, Cordaid, the UNFPA, and Rutgers. Munsero and Birgrimana's (2017) baseline study provides both a summary of the intervention and the baseline findings prior to the implementation of the program. The intervention has four main components: comprehensive sexuality education in the form of study modules in school and "community facilitator guides" for those out of school, improvement of accessibility to SRH services for young people, working with EU level influencers to support young people's access to services and information, and effective coordination throughout the program. The target group of the Joint Program is adolescents and young people aged 10 to 24 who are either in or out of school. The study uses seven outcome indicators: number of adolescents and young people who have skills in promoting and protecting their sexual and reproductive health and rights (SRHR), who have sufficient knowledge of SRH, who have positive attitudes towards SRH, who have unmet needs for SRH services, who used a condom during last sexual intercourse, whose local leaders support their access to SRH information and services, and whose families support their access to SRH information and services.

### **Discussion**

Ensuring that young people in Burundi have sufficient knowledge over SRH issues is paramount. As stated, while knowledge on HIV/AIDS is remarkably high amongst Burundian youth, SRH knowledge

exceeding this is extremely limited (Munsero and Birgrimana 2017). Gaps in SRH knowledge contribute to bad SRH practices (Ott *et al* 2010). Providing comprehensive sexuality education has been found to decrease the likelihood of adolescent girls getting pregnant (Maness *et al* 2016; Molina *et al* 2004; Yakubu and Salisu 2018) as girls, and boys, learn about how pregnancy occurs and the different methods to successfully prevent it. By giving sexuality education both inside and outside of school, the Joint Program should help reduce adolescent pregnancy. Furthermore, by providing it outside of school and with a target age of up to 24, the Joint Program should compensate for young people beyond schooling age who did not receive comprehensive sexuality education whilst at school and would otherwise miss the opportunity despite its introduction.

Providing easy access to SRH information and services, is important in fostering better SRH practices among Burundian adolescents and youth. The Joint Program's baseline report states that 78.8% of households had access to SRH services and health services within 5km of which 92.8% in urban areas and 77.3% in rural areas (Munsero and Birgrimana 2017). However, it is unclear what services exactly are available at these centres – what information is provided, how this information is delivered, and what contraceptive methods are available and to whom. Furthermore, the low proportion of adolescents (4.8%) having used SRH services once (Twungubunwe 2016) show that other factors are clearly at play. Accessibility is not only a question of what is accessible and where, but also how socially accessible and acceptable SRH services are.

Familial support will prove key in influencing adolescents' and youth's SRH practices as this will set the stage for better (continued) use of SRH services and utilisation of this knowledge in their lives. It is known that speaking about SRH issues in many low- and low-middle income countries is a social taboo (Ayalew 2010; Mkhwanazi 2010; Tesso 2012) and this has been found to be the case in Burundi as well (Munsero and Birgrimana 2017). This can make it very difficult for parents to talk openly with their children about SRH issues and encourage good SRH behavior, including encouraging their use of SRH services. Bad quality communication has been observed in which SRH issues are confronted in a threatening manner

(Tesso 2012). However, good quality communication on SRH issues between parents and adolescents has shown to reduce rates of adolescent pregnancy (Abosetugn *et al* 2015; Ayalew *et al* 2014; Izgubra 2008). Good quality communication would involve supporting a child's use of SRH services. This in turn has the potential to improve adolescent pregnancy rates. Unfortunately, the Joint Program does not clearly explain how familial support of SRH services will be encouraged.

Given that the support from local leaders is critical, the Joint Program recognizes them as key actors in influencing public opinion in several areas including adolescent and youth SRH and has involved them as such in community mobilization sessions. Local leaders are viewed by locals as credible and reliable sources of information (Elkins *et al* 1998) even if this is not the actual case. Leaders have the potential to sabotage efforts to improve SRH services and access to these services as well as to defy public opinion and advocate in favor of them (Lee *et al* 2009). In a study in West Java, Indonesia, it was found that local leaders were more likely to understand and support a family planning program if they were more closely involved in its implementation (Utomo *et al* 2006).

In the mid-term evaluation of the Joint Program, the religious leaders acknowledge that the program has increased their awareness on SRH challenges faced by youth. However, it is important to note that their position remains ambiguous and very critical in relation to youth sexual health. While they agree that inaction on SRH among youth would cost more than action, they do not hesitate to oppose some prevention means (such as condoms) and the comprehensive sexuality education curriculum module 'The World Starts with Me' to help young people to discuss and confront sensitive issues (Batungwanayo, Mpinganzima & Bizoza 2019).

Therefore, strategies need to be devised in which local leaders are brought on board of interventions to convince them of the interventions' importance, to secure a positive community opinion of such interventions, and to prevent the local leaders becoming obstacles to implementing interventions. This needs to be a conscious effort, and not left up to chance.

Implementation of the Joint Program should be cautious of the potential for counterproductive effects. Several studies on interventions against adolescent pregnancy have shown such effects (see Dupas 2011; Fikree *et al* 2017; Speizer *et al* 2018). Furthermore, several studies have found that whilst one component is effective on its own, this effect is negated in combination with other intervention components. For example, Duflo *et al* (2015) found that while school uniform provision reduced the likelihood of adolescent girls becoming pregnant, no reduction was found when this was combined with HIV prevention training to three teachers in the school to help them teach the national HIV/AIDS curriculum. The Joint Program contains a great number of components working in tandem. Although they each may have certain effects and the combination of these effects might lead to the desired outcomes, they may also work against each other.

Close caution should therefore be paid in regard to the effect of these intervention components on adolescent pregnancy, even if adolescent pregnancy is not an outcome measure. Admittedly, (adolescent) pregnancy is difficult to measure (Hindin *et al* 2016), mostly because many pregnancies, births, and abortions go unreported.

The mid-term evaluation of the Joint Program documented changes in relation with the program activities. These include changes in youth behavior, through the development of knowledge and awareness about responsible sexual and reproductive health. Peer education has helped youth building their self-esteem and feeling valued in their community. Testimony figures related to a reduction in the number of unwanted pregnancies in schools and increased support of parents and religious leaders to the program (Batungwanayo, Mpinganzima and Bizoza 2019).

A greater understanding of girls' SRH knowledge and experiences can be gained by measuring proximate behavioral changes specific to girls, such as the use of long-acting reversible contraceptives or menstrual calendars as a form of birth control. None of these are measured in the Joint Program which will leave the effects it has on adolescent pregnancy unclear.

## Conclusion

The Joint Program has the potential to affect adolescent pregnancy rates in Burundi in a desired manner. The outcome indicators attempt to understand and measure SRH problems faced by adolescents and youth. Although adolescent pregnancy is not an outcome measure of the Joint Program, it can be influenced by the intervention components that, in other studies, have been used to address adolescent pregnancy. The first results of the mid-term evaluation are promising. However, as has been observed in other studies, interventions of this type, even if they positively influence certain behavioral changes, they can have negative or counterproductive effects. Without monitoring teenage pregnancy rates, the Joint Program risks losing its potential to have very real and beneficial impacts on Burundian girls or worse, leaving them more vulnerable to early pregnancies and the variety of consequences that change their life.

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