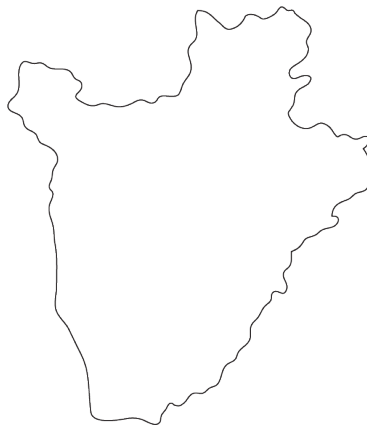


How the “Joint Program” Intervention Should or Might Improve Adolescent Pregnancy in Burundi, How These Potential Effects Could Be Encouraged, and Where Caution Should Be Given.



Harry French
Share-Net International/Yes I Do Research Intern
KIT Royal Tropical Institute
Amsterdam

Introduction

Adolescent pregnancy 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 work force 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, pregnancy rates amongst adolescent girls are 7.3% in Rwanda (UNFPA 2016a), 25% in Kenya (Gitau *et al* 2016), 26.7% in the Democratic Republic of Congo (UNICEF 2016), 27% in Tanzania (National Bureau of Statistics [Zanzibar] 2016), 32.6% in Ethiopia (Kassegne *et al* 2018), and, with the highest rate in the region, 63% in Uganda (Uganda Bureau of Statistics 2014). In Burundi, 8% of teenage girls fall pregnant (Institute of Statistics and Economic Studies of Burundi 2017). Although Burundi is on the lower end of these countries, 8% is still very high. 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Ministry of Education announced a “blanket” ban on pregnant girls and expectant fathers attending school, a ban that was retracted a month later (Bhalla 2018). This ban would have only worsened the prospects for 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. The focus of Share-Net Burundi is best strategies to prevent and reduce adolescent pregnancy. In line with this focus, this paper explores the Programme Conjoint pour l’Amélioration de la Santé Sexuelle et Reproductive des Adolescents et

Jeunes de 10-24 ans au Burundi, or the Joint Program to Enhance Sexual and Reproductive Health of Adolescents and Young People of 10-24 Years in Burundi and 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. Whilst 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 and therefore they may influence it. 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 despite this not being a primary focus, and how these potential effects could be encouraged further should the intervention be repeated or a similar intervention be carried out in the future.

To do this, first adolescent pregnancy is contextualised in Burundi by exploring what is and is not known about it 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. Thereafter, the Joint Program is 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 pregnancy every year (UNFPA 2015). 11% of births worldwide belong to adolescent girls 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) and 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 after a girl has been married (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 (Institute of Statistics and Economic Studies of Burundi 2017). In contrast to general relationship between adolescent pregnancy and child marriage, activists in Burundi state that the majority of pregnancies occur outside of marriage with girls often forced to marry due to their pregnancy (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) although it is unclear how these relate to pregnancy. Despite the lack of knowledge on adolescent pregnancy in Burundi, by looking at proximate factors this phenomenon can be contextualised and further informed.

Burundi exhibits significant shortcomings in regard to the knowledge, attitudes, and practices 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 & 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 & 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 (*ibid*). Moreover, many youths 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 (*ibid*). This leaves unclear how youth friendly Burundian SRH services are and whether they proactively take into account the difficulties, prejudices, and barriers that adolescents and youths wishing to use their services might face in doing so.

SRH practices amongst adolescents and youth in Burundi are particularly striking. Between 2009 and 2012 there were 4760 pregnancies to girls aged 13-22, with the majority being to girls aged 14-18, meaning that 11% of all girls 15-19 had already had a child (UNFPA 2013). By 2016 this had decreased to 7% (UNFPA 2016b), however this figure is still very high. 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 using SRH services once (Twungubumwe 2016), a statistics that is significantly worrying.

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. 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 both in and out of school. The study uses seven outcome indicators: how many 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 persons in Burundi have sufficient knowledge over SRH issues is paramount. As stated, whilst knowledge over HIV/AIDS is remarkably high amongst Burundian youth, SRH knowledge outside 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 falling pregnant (Maness *et al* 2016; Molina *et al* 2004; Yakubu and Salisu 2018) as girls, and boys, learn about how pregnancy begins and the different methods by which they can 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 persons 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, furthermore, is critically important in fostering better SRH practices amongst Burundian adolescents and youth. Even though it states the figures should be treated with caution, the Joint

Program’s baseline report states that 78.8 % of households had access to SRH services and health services within 5km, a statistics that changes to 92.8% in urban areas and 77.3% in rural areas (Munsero and Birgrimana 2017). These *seem* like good statistics. What is left unclear is exactly what services are available at these centres – what information is provided, how this information is delivered, and what contraceptive methods are available and to who. Furthermore, 4.8% of adolescents having used SRH services once (Twungubunwe 2016), other factors are clearly at play. Accessibility is not only a question of what is accessible and where, but also how socially accessible, that is how socially 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 be a social taboo (Ayalew 2010; Mkhwanazi 2010; Tesso 2012) and this has been found to be the case in Burundi (Munsero and Birgrimana 2017; UNFPA 2013). This can make it very difficult for parents to talk openly with their children about SRH issues and encourage good SRH behaviour, including encouraging their use of SRH services. Bad quality communication has been observed in which SRH issues are confront in a threatening manner (Tesso 2012). However, good quality communication over 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 no doubt involve supporting a child’s use of SRH services. This in turn has the potential to improve adolescent pregnancy rates. Unfortunately, the Joint program leaves unclear exactly how familial support of SRH services will be encouraged.

Despite support from local leaders being critical, the Joint Program also gives no explanation of how this would be encouraged. 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 them as well have having the potential to defy public opinion

and advocate in favour 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 programme if they were more closely involved in its implementation (Utomo *et al* 2006). Therefore, strategies need to be devised in which local leaders are brought on board 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 been found to have 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 whilst school uniform provision reduced the likelihood of adolescent girls becoming pregnant, when this was combined with HIV prevention training to three teachers in the school to help them teach the national HIV/AIDS curriculum, no reduction was found. The Joint Program contains a great number of components working in tandem. Each may have certain effects and in combination these effects may be expected and desired outcomes, or they may work against each other.

Close caution should therefore be paid in regard to the effect of these intervention components on adolescent pregnancy, despite adolescent pregnancy not being an outcome measure. Admittedly, (adolescent) pregnancy, admittedly, is difficult to measure (Hindin *et al* 2016), mostly because many pregnancies, births, and abortions go unreported. However, getting rough estimates are not impossible. Furthermore, by measuring

proximate behavioural changes specific to girls, such as the use of long-acting reversible contraceptives or menstrual calendars as a form of birth control, a greater understanding of girls' SRH knowledge and experiences can be gained. 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 effect adolescent pregnancy rates in Burundi in a desired manner. The outcome indicators attempt to understand and measure SRH problems faced by adolescents and young persons. Although adolescent pregnancy is not an outcome measure of the Joint Program, it may be influenced because these intervention components have been used, in other studies, to confront adolescent pregnancy. This intervention is certainly more promising than the now reversed ban on pregnant girls and expectant boys attending school, however it is not guaranteed that the Joint Program will reduce adolescent pregnancy rates. As found in other studies, interventions of this sort, whilst positively influencing some behaviour changes, often have no effects, or they may have negating or counterproductive effects. Adolescent pregnancy rates could therefore remain unchanged or even be encouraged. Without monitoring adolescent pregnancy rates, the Joint Program risks discarding its potential to have very real and beneficial impacts on Burundian girls or worse, leaving them more vulnerable to early pregnancy and the life changing variety of consequences.

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