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Exploring Couple Dynamics with First-Time Parents in Burkina Faso and Acceptability of Couple-Focused Interventions to Improve Their Sexual and Reproductive Health

TECHNICAL REPORT | E2A PROJECT



About E2A

The Evidence to Action (E2A) Project is USAID's global flagship for strengthening family planning and reproductive health service delivery. The project aims to address the reproductive health care needs of girls, women, and underserved communities around the world by increasing support, building evidence, and leading the scale-up of best practices that improve family planning services. A Cooperative Agreement awarded in September 2011, E2A is led by Pathfinder International and will end on March 31, 2021.

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ACRONYMS AND ABBREVIATIONS

ANC	Antenatal care
CFI	Couple-focused intervention
CHW	Community health worker
CPR	Contraceptive prevalence rate
E2A	Evidence to Action
FGD	Focus group discussion
FP	Family planning
FTM	First-time mother
FTP	First-time parent
GBV	Gender-based violence
HTSP	Healthy timing and spacing of pregnancy
IDI	In-depth interview
MIL	Mother-in-law
MOH	Ministry of Health
RH	Reproductive health
RMNCH	Reproductive, maternal, newborn and child health
SRH	Sexual and reproductive health
USAID	US Agency for International Development

I. INTRODUCTION

The Evidence to Action (E2A) project has drawn global attention to an important subset of youth—first-time parents (FTPs)—defined as young women under the age of 25 years who are pregnant with or have one child, and their male partners. E2A’s experiences in implementing FTP programs in Burkina Faso, Nigeria, and Tanzania have revealed that young parents want to discuss and address couple relationship issues, such as communication and conflict management. These programs had been reaching young men and women separately, rather than as a couple, but due to FTPs’ high level of interest in discussing relationship topics, E2A added a couple-focused component to its Burkina Faso FTP project in 2019.

Couple-focused interventions¹ (CFIs) are a potentially valuable strategy for addressing FTPs’ concerns and accelerating progress toward achieving sexual and reproductive health (SRH) goals.² However, although a large proportion of adolescents are already married in many low-income countries like Burkina Faso, little is known or has been written about the nature, needs and concerns of adolescent and youth couple relationships and how the relationship influences SRH decisions and behaviors. Recognizing the relative invisibility of young couples in the SRH literature and policy arena, and given our program experiences working with FTPs in Burkina Faso, E2A aimed to examine the nature of the couples dynamic among youth and further explore the potential for CFIs within the FTP framework, which recognizes the needs, relationship dynamics, and gender and social norms that influence young parents’ health and wellbeing over the course of the FTP life stage. This report presents the findings from this qualitative study and offers insights that may be useful to guide future FTP programming efforts in Burkina Faso.

¹ The term couple-focused intervention applies only to public health practice. CFIs conceptualize ‘the couple’ as the basic unit that the intervention targets. These interventions seek to change one or more elements of that relationship to achieve an explicit couple-focused (e.g., couple communication) or individual reproductive health outcome (e.g., women’s utilization of a modern contraceptive method)—whether that intervention is conducted wholly together as a couple, or using a synchronized approach (i.e., working in an intentional manner with both members of the couple, though not necessarily at the same time). M. Greene, A. Levack A. *Synchronizing Gender Strategies*. (Washington, DC: Population Reference Bureau, 2010).

² E. Ramirez-Ferrero, *Couple-Based Approaches in Reproductive Health: Implications for Global Policy, Practice, and Research* (Washington, DC: E2A Project, March 2021).

II. BACKGROUND

First-time mothers (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 Burkina Faso, particularly in the Eastern Region, sexual debut and childbearing generally occurs within the context of marriage and that the interval between marriage and first birth is relatively short. According to the 2010 Burkina Faso Demographic and Health Survey, the median age of marriage for women in the Eastern Region is 17.2 years, the median age at sexual debut is 17.3, and the median age at first birth is 18.4.³ Contraceptive use is low, with a modern contraceptive prevalence rate (CPR) of 10.8%, compared to the national modern CPR of 15.3%; national levels of contraceptive use by younger women are even lower, with just 5.9% of adolescents aged 15-19 years using a modern contraceptive method.⁴ Given early childbearing and low levels of contraceptive use, it is no surprise that the Eastern Region has the highest total fertility rate in the country at 7.5 children per woman.⁵

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.⁶ 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.⁷ 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.

In this context with 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.

³ Institut National de la Statistique et de la Démographie (INSD) et ICF International. *Enquête Démographique et de Santé et à Indicateurs Multiples du Burkina Faso 2010*. (Calverton, MD: INSD et ICF International, 2012).

⁴ Ibid.

⁵ Ibid.

⁶ A. Engebretsen, G. Kabore, “Addressing the needs of girls at risk of early marriage and married adolescent girls in Burkina Faso.” *Promoting Healthy, Safe, and Productive Transitions to Adulthood Brief no. 9*. (New York, NY: Population Council, May 2011).

⁷ Ibid.

A. E2A's FTP Project in Burkina Faso⁸

From April 2018 to June 2019, E2A implemented the “Supporting Reproductive Health Services for Young First-Time Parents in Burkina Faso” project, in collaboration with the Ministry of Health (MOH) and Pathfinder International Burkina Faso. The overall objective of the project was to increase FP uptake and the use of RMNCH care—especially antenatal care (ANC) and obstetric and neonatal services—among FTPs. The project worked at both the facility and community level in two districts in the Eastern Region, Diapaga and Fada, covering a total of 20 health facilities and 57 surrounding villages. Reflecting a life stage and socioecological approach⁹, interventions focused on increasing utilization of ANC, FP and obstetric and neonatal services and advancing related gender outcomes by targeting individual knowledge, attitudes and behaviors while also strengthening the support of household and community members who influence FTM/FTP's health actions. The interventions package included peer groups for FTMs, household visits, outreach with key influencers such as mothers-in-law (MILs) and husbands, radio broadcasting, and support for health facilities.

Based on the positive results achieved in the first phase of the FTP project in Burkina Faso, E2A received an extension to continue the project for an additional year. The planned dates of this second phase was July 2019 to June 2020¹⁰, supporting a new set of 20 health facilities and 20 villages in the Eastern and Center North regions of the country, with the same goal of increasing access to and use of quality RMNCH care for FTPs and their children. Phase 2 of the program continued with many of the key intervention components of Phase 1 while also adding new topics for FTM peer groups, more systematic outreaches with men and older women, and a CFI component, the elements of which included the following:

- The timing and key topics covered by the FTM peer group sessions and the group sessions for husbands were synchronized. Topics included safe pregnancy and delivery, healthy timing and spacing of pregnancy (HTSP), FP, and gender roles.
- Joint couple sessions that brought together FTMs and their husbands to discuss key health topics, including ANC and HTSP/FP.

Unfortunately, due to the COVID-19 pandemic that led to a cessation of group interventions, the husbands' session on gender roles as well as the joint couple session on HTSP/FP were not completed.

⁸ For more information about FTP program in Burkina Faso, see the report [here](#).

⁹ To read more about the life course approach and socioecological lens E2A applies to FTP programs, visit www.e2aproject.org/FTP

¹⁰ Phase 2 activities ended in March 2020 due to the COVID-19 pandemic.

B. Couples-Focused Interventions

In this study, the term couple-focused intervention is defined as an intervention that conceptualizes “the couple” as the basic unit of intervention and seeks to change one or more elements of that relationship to achieve an explicit couple-focused or individual health outcome, targeting both members of the couple either together or using a synchronized¹¹ approach (ie. working in an intentional manner with both couple members though not necessarily at the same time). Examples of a couple-focused outcome may include communication within the couple and joint decision-making, while examples of an individual health outcome may include a woman’s attendance in antenatal care services or her utilization of modern contraception.

The literature on CFIs is limited and drawn predominantly from the field of HIV.¹² However, existing evidence suggests that CFIs are equally or more effective in achieving desired reproductive health outcomes than interventions that focus on individual couple members alone.^{13,14} Given this, E2A recognized that CFIs represent an opportunity for gender-transformative programming to address the dynamics of relationships of FTP couples—in terms of power, communication, and decision-making—and alter the perception of male partners as obstacles to reproductive health to a constituent component of reproductive health service delivery and policy.¹⁵ However, despite their potential, the widespread implementation of CFIs has been inhibited by a distinct set of barriers:¹⁶ 1) reproductive health is largely considered within women’s sphere of action, even among SRH professionals; 2) the logistics of male involvement, which relates to how to effectively recruit, reach and retain men; and 3) the demands required to provide couple-focused services across a health system that is not accustomed to accommodating men.

¹¹ M. Greene, A. Levack A. *Synchronizing Gender Strategies*. (Washington, DC: Population Reference Bureau, 2010).

¹² E. Ramirez-Ferrero, *Couple-Based Approaches in Reproductive Health: Implications for Global Policy, Practice, and Research* (Washington, DC: E2A Project, March 2021).

¹³ Ibid.

¹⁴ S. Becker, “Couples and reproductive health: a review of couple studies” *Stud Fam Plann.* 1996;27(6):291–306.

¹⁵ Theuring S, Mbezi P, Luvanda H, Jordan-Harder B, Kunz A, Harms G. Male involvement in PMTCT services in Mbeya Region, Tanzania. *AIDS Behav.* 2009 Jun;13 Suppl 1:92–102.

¹⁶ E. Ramirez-Ferrero, *Couple-Based Approaches in Reproductive Health: Implications for Global Policy, Practice, and Research* (Washington, DC: E2A Project, March 2021).

III. STUDY OBJECTIVES

The objectives of this study were twofold: to gain insights on how FTP couples interact and act on SRH issues and to identify ways in which programs can foster communication, joint learning and mutual support, joint decision-making and positive SRH actions using a couple-focused approach with FTPs. The main research questions corresponding to each study objective are listed below.

Objective 1: To gain insights on how FTP couples interact and act on SRH issues

- How do FTMs and their partners define “couple”?
- What are the dynamics of communication and decision-making about SRH among FTPs? How does gender inequality and power differentials influence this?
- What was the experience of FTMs in their decision to use a contraceptive for the first time and their choice of method? What was the nature of the partner’s involvement in that decision? Is there a difference in the dynamics among couples for FTMs who use FP compared with those who don’t?
- What are the primary barriers and facilitators that FTPs face that hinder or enable communication and joint decision-making about SRH issues?
- What are the primary barriers and facilitators that FTPs face that hinder or enable access to and utilization of SRH services – as individuals or as a couple?
- Do FTPs feel that activities focused on the couple would be acceptable? Beneficial? Why or why not?

Objective 2: To identify ways in which programs can foster communication, joint learning and mutual support, joint decision-making and positive SRH actions using a couple-focused approach with FTPs

- What are the programmatic implications of how “couple” is defined by FTMs and their partners?
- Are couple-focused interventions for FTPs at the community and facility level feasible for implementation? (eg. Home visits for couples, small group meetings for couples, facility-based couples counseling for ANC and FP, partners as birth companions)
- What kind of health system—or facility—changes would need to be made to accommodate this kind of programming?
- What are the ethical/consent issues involved in SRH services focused on couples? How can those issues be addressed programmatically or logistically?
- How can programs better engage and reach men?

- What policies and guidelines, as well as facility and community-level support structures, currently exist that would enable implementation of couple-focused interventions for FTPs?
- What are the views of key influencers at all levels of socioecological model on the acceptability of couple-focused interventions for FTPs?
- What interventions would be needed at all levels of the socioecological model to ensure a supportive and enabling environment for couple-focused interventions?

IV. METHODS

A. Study Design

This study is a formative assessment using qualitative methods to gain a more in-depth understanding about FTP couples and the potential for implementing CFIs for FTPs. Specifically, in-depth interviews (IDIs) were used to examine couple dynamics among FTPs and explore the feasibility and acceptability of CFIs from the perspective of FTMs enrolled in E2A's FTP program, their husbands, health facility providers, and government health officials at district and national levels in Burkina Faso. Focus group discussions (FGDs) were used with mothers-in-law and community health workers mothers-in-law and community health workers (CHWs) to leverage group dynamics to spur conversation about social norms and practices in the community related to couple's communication, decision-making and care-seeking for reproductive health and family planning.

This study was conducted by a team of 10 Burkinabe research assistants at the Masters and Bachelors level in Sociology, under the supervision and technical leadership of a senior investigator in Burkina Faso with a doctorate in sociology and extensive experience in qualitative research. This team also drew from the expertise of a US-based gender specialist consultant, as well as E2A technical staff, including the Senior Monitoring, Evaluation, and Learning Advisor, the Senior Youth Advisor, the Program Officer for Field Support, and the Technical Director.

B. Study Participants

The study was conducted in six villages in the districts of Fada and Kaya where the E2A FTP project has been implemented. Both areas are characterized by relative insecurity due to repeated attacks by unidentified armed individuals. The study villages were selected based on a purposive, convenient sampling strategy limited to relatively peaceful areas and were guided by the Pathfinder Regional Project Coordinators based in each district in order to ensure maximum safety for investigators, respondents and supervisors. See Table 1 for the names of the selected study sites.

Table 1: Study sites

District	Commune	Health Center	Village
Fada	Diapangou	CSPS de Diapangou	Comboari
	Diabo	CSPS de Diabo	Boulyaoguin
		CSPS de Moadà	Moadà
	Tibga	CSPS de Tibga	Bilentenga
Kaya	Pissla	CM Pissla	Pissla
	Kaya	CSPS of Sect 6 Kaya	Silmiougou

The table below lists the targeted population groups and the inclusion criteria for participation in the study.

Table 2: Inclusion criteria by study respondent group

Respondent	Inclusion criteria
FTM	- First-time mother between 15 and 24 years of age - Has participated in at least 4 of the program's home visits or small group meetings
Husband of FTM	- Husband of a FTM participating in the study
MIL	- Mother-in-law of a FTM participating in the study - Lives regularly with the couple selected for the study
CHW	- CHW working in the project-supported village for more than 12 months
FP/RH health providers	- Has worked in a health center supported by the FTP project for more than 6 months
RH district managers	- Member of the district management team responsible for reproductive health, or a deputy to the RH manager
National health authorities	- Responsible for implementing maternal and family health programs in the country

The selection of the first-time mothers who were eligible for the study was based on the monitoring database managed by the FTP project managers in each village, which lists all of the FTMs enrolled in the project along with their contact information. Pathfinder International Burkina Faso's two regional program managers in Fada and Kaya were mobilized to inform the managers of health facilities and CHWs about the study. The CHWs then contacted eligible individuals in their communities by phone to invite them to participate in the study. If they confirmed that they would participate, then their husband and mother-in-law were also contacted and invited to participate.

In addition, the CHWs, health providers (typically the head of the maternity ward and the head nurse of selected facilities), the district RH manager in each district were contacted and invited to participate if they met inclusion criteria. At the national level, data collectors selected to interview two individuals responsible for implementing maternal and child health programs in the country, with experience in FP/RH.

For focus groups, study participants (CHWs and MILs) were gathered in convenient locations, often at the health center. For individual interviews, couples identified in advance in the monitoring databases were contacted by phone and joined by study teams in their village to avoid travel. Eligible participants received an explanation of the study's objectives, their rights if they choose to take part and their right to refuse. With the institutional participants (health providers, district RH manager and national officials), a date and time was scheduled by telephone before data collectors arrived for the interviews. It should be noted that a letter of introduction from the general secretariat of the MOH was required before the start of the interviews.

C. Description of Tools

The study tools used for the FGDs and IDIs were developed in French by the lead investigator, with inputs from the E2A technical team, as well as the gender specialist consultant, whose contributions helped to ensure the tools were gender sensitive and rooted in the "do no harm" principle. All tools were pre-tested, which led to minor adjustments to improve the wording and language of the questions to make them clearer to study respondents. The tools included 10-15 questions on average and were designed to take no more than one hour to administer. The tools explored social meanings of the concept of a couple; how women and men understand their respective roles within the couple; communication dynamics within the couple; perceptions of FP among FTMs, their partners, and their mothers-in-law; the experiences of the use of FP among young women and young men; the decision-making process within the couple, including power dynamics; the feasibility and acceptability of a couple-focused intervention, including the potential obstacles and factors favorable to the implementation of such an intervention.

In addition, a field data collection guide with clear standard operating procedures was developed as a checklist for investigators and supervisors. A COVID-19 safety guide was also produced with the support of Pathfinder International Burkina Faso's Security Officer.

D. Training and Piloting

The training of data collectors took place from August 31-September 2, 2020 at the National Cardinal Paul Zoungana Center in Ouagadougou. The purpose of this training was to familiarize participants with the data collection tools and techniques for collecting gender-sensitive data using IDIs and FGDs. There were ten participants, 7 women and 3 men, all sociologists with a Masters or Bachelors degree. The primary trainer was the lead investigator, supported by E2A's Senior Youth Advisor based in Ouagadougou as well as the gender specialist consultant who facilitated remotely from the US through a virtual platform (Zoom). The training included a review of research ethics principles and protocols, as well as COVID-19 safety measures, with which all study members must comply.

At the end of the three-day training, the study team pre-tested the tools in the village of Tangasgo, located 10km from the city of Kaya to better adapt them to local contexts. The purpose of the pre-test was to ensure that the questions were understandable by the respondents and that they are in line with social values and norms. The pre-test also led the team to revisit the tools due to their length and address difficulties in translating certain indigenous words into French as well as some concepts in the local language.

Fifteen FTMs volunteered to participate in the pre-tests; after four IDIs were conducted, data collectors opted to also conduct FGDs with the remaining FTMs given their enthusiasm to participate. The data collectors noted that the FTMs in the FGDs were more vocal about the "intimate" topics raised by the study tool due to the dynamics of the group. On the other hand, only one interview with a husband was

conducted, as many were not present in the village at the time of the pre-test due to reasons of displacement. A total of 7 IDIs and 3 FGDs were conducted as part of the pre-test (see Table 3 below).

Table 3: Profiles of respondents during the pre-test in the village of Tangasgo, Kaya district

		Number Conducted	Language
In-depth interview	FTM	4	Moore
	Husband	1	Moore
	Provider	2	French
Focus group	Mother-in-law	1	Moore
	CHW	1	Moore
	FTM	1	Moore

The tools were adjusted on September 3, 2020 based on issues that were raised during the pre-tests. After a follow-up meeting with the E2A technical team on September 18, 2020, the number of questions in the various tools was also reduced due to the length of certain interviews, and all of the tools were finalized for the study. A training/refreshment workshop to review the final study tools was conducted with field supervisors and data collectors on September 23, 2020.

E. Data Collection

Data collection took place from September 25-30, 2020 in the six selected villages in Fada and Kaya districts. Pathfinder International Burkina Faso's regional teams were mobilized to inform local authorities, community leaders and CHWs in advance of scheduled arrivals of the data collectors.

The team of ten investigators (2 supervisors, 8 data collectors) was divided into two separate groups, each traveling to and collecting data from three villages. Investigators worked in pairs so that one asked the questions while the other took notes in the field log.

The day before data collection began, the study team met to review the field implementation procedures and COVID safety guidelines. During the data collection, the study team explained to participants the need to wear masks, maintain physical distance and apply hand sanitizer for the group discussions and interviews, as these measures help to prevent the spread of COVID-19. All study participants complied with these measures.

The study team conducted a total of 58 in-depth individual interviews and 16 focus groups with a total of 177 people (see Table 4). The group discussions were conducted with women and men separately, facilitated by a female data collector. For individual interviews, female participants were interviewed only by female data collectors, while male participants were interviewed by men. The table below shows the final sample size obtained for each group of study participants.

Table 4: Study sample, by respondent group, data collection method and district

	Kaya		Fada		Total	
	Number	Number of people	Number	Number of people	Number	Number of people
IDI – FTM	09	09	16	16	25	25
IDI – Husband	11	11	09	09	20	25
IDI – Provider	03	03	08	08	11	11
IDI – District Manager	01	01	01	01	02	02
Total IDI	24	24	34	34	58	58
FGD – MIL	03	26	04	23	07	49
FGD – FTM	02	23	01	05	03	28
FGD – CHW	02	14	04	28	06	42
Total FGD	07	63	09	56	16	119
Total participants						177

Field supervisors were responsible for conducting regular meetings with data collectors. Follow-up meetings were held daily to debrief on the teams' achievements, highlighting any difficulties and discussing proposed solutions. The team also created and used a Whatsapp group to facilitate exchanges between the two teams. In addition, to monitor the team's capacity to transcribe the data and help ensure quality, each investigator transcribed a file during the data collection period, which was then reviewed and corrected as needed by the field supervisors.

F. Data Analysis

The audio files of the IDIs and FGDs were transcribed directly from the local language into French. All the transcripts were completed and shared with the lead consultant by mid-November. A total of 2,100 pages of transcripts were used for thematic and lexical analysis. The transcribed texts were imported into NVivo, a software for qualitative data analysis. Codes used in the analysis were created based on the key themes and sub-themes raised in the study tools, and later adjusted and complemented with other themes that emerged from transcripts.

The lead investigator conducted and presented a preliminary analysis of the data to E2A technical staff and the gender specialist consultant to discuss findings and address questions and gaps in the analysis. He then incorporated their contributions and feedback into the final analysis and write-up of study findings.

G. Ethical and Safety Considerations

The protocol for this study was approved by the National Ethics Committee for Health Research in Burkina Faso (ref: 2020-08-142) on August 12, 2020. PATH's Research Determination Committee determined on January 28, 2020 that the study was not research and thus considered exempt from needing review and approval from PATH's Institutional Review Board. The study also secured support from the Ministry of Health (letter no. 2020/2936/MS/SG/DGSP/DSF) and the Ministry of Women, Family, National Solidarity and Humanitarian Action (letter no. 2020/2270/MFSNFAH/SG).

The study was designed in accordance with ethical principles, including respect for persons, beneficence, justice, and respect for the law and the public interest. Efforts were made to protect individual autonomy, respect privacy and confidentiality, minimize harm, maximize benefits, ensure data security, and equitably distribute risks and benefits. Due to the sensitive nature of some of the questions in the context of conflict-related displacement and the potential for gender-based violence (GBV), data collectors were prepared to offer referrals for local psychosocial services to any study participants who appeared to have experienced GBV-related trauma. All study team members were given ethics and data confidentiality training so that they fully understood the concepts of informed consent and confidentiality. A written consent process was administered with each participant at the time of interview. The interviewers also sought permission to both interview and record. Participation in the study was voluntary and participants had the right to withdraw from the study at any time, without any sanction. To ensure confidentiality, transcripts did not include identifiers and only used unique codes assigned to each respondent.

In addition, the study ensured that national COVID-19 safety measures were enforced among study team members and participants to minimize the risk of spreading the virus during training, pre-testing of tools, and data collection. These measures included: respect for social distancing; wearing a mask over nose and mouth at all times; and regular handwashing with soap or hand sanitizer. The supervisors and investigators were trained in these prevention practices, as well as the steps for responding to any instances of possible exposure. COVID-19 related guidelines were outlined in a field guide provided to all study team members. Finally, the study team was provided with hand sanitizer and masks for use during data collection, allowing them to offer masks to study participants as needed.

H. Implementation Challenges

There are a few study limitations that are worth noting, which primarily are due to implementation challenges encountered on the ground. These include the following:

- The security issues in some of the study sites may have affected participation levels, especially among FTMs and their husbands. Participation in Kaya, where insecurity is less severe, was better than in Fada, where there were many people who have been displaced from their communities. In addition, interviews with some health providers were cut short when they had to leave early to travel home—in these situations, their places of residence were far from the study site due to insecurity around those areas.
- When the husbands of FTMs were absent, several men presented themselves as husbands even though they were actually *tuteurs*, or “guardians”. The phenomenon of “guardians” of women is based on the social norms of the woman belonging to the family lineage rather than simply being the wife of a single person. As a result, the absence of the legal husband does not make the wife “a woman without a husband.”¹⁷ Some of the men were subsequently not interviewed once the relationship was clarified, but they expressed their displeasure saying that they had participated in the project activities.
- The study team was surprised to find that in Boulyaoguin village, Zaoré and Fulfuldé are the dominant dialects spoken. These local variations of Mooré were not understood well by data collectors, which led them to identify study participants that spoke in the Mooré dialects familiar to the study team members.

¹⁷ According to our understanding, when the husband travels, he entrusts his wife to one of his brothers to look after her. He acts as a “guardian” of the woman. It seemed to us that these “guardians” were involved in the activities of the project instead of the actual spouses. It is during the interview that one realizes in terms of his profile that he is not the “legal” husband of the woman. It is also a strategy to exercise social control over women’s daily lives in the form of surveillance.

V. STUDY RESULTS

A. Defining couple relationships

As a first step to examining the dynamics of couple relationships, the study looked to how FTPs, as well as their MILs and the CHWs in their communities, define and understand the concept of “couple”. A clear consensus emerged among study respondents that a couple is a man and a woman who are married.

If there has been no marriage between you, we cannot call you a couple. Without marriage, we will call the man what the French call "single". That is, a man who does not have a wife. With marriage, the woman belongs to you and you belong to her also.

—Husband, 29 years old, Comboari, Fada

However, study respondents distinguished between two types of marriages: those that were arranged or forced between two individuals, sometimes with significant age differences, and those chosen by the couple, which was more common among young couples of the same generation.

Forced or arranged marriage

During the interviews, several individuals highlighted the persistence of early, parent-imposed marriages. The following dialogue with a 19-year-old FTM is illustrative.

Interviewer: *But is that where you met your husband?*

FTM (19 years old, Silmiougou, Kaya): *I didn't know my husband previously. I met him when I married him. Otherwise we didn't know each other.*

Interviewer: *Didn't you meet each other before the wedding?*

FTM: *No.*

This young woman was in a situation of displacement with her parents. Through one of her uncles, she was given in marriage to a 23-year-old man who works as a security guard in Kaya. While her husband was also young, she indicated that she would not have been able to refuse the marriage even if he was elderly because the marriage is her parents' choice. Their wedding was celebrated at the town hall and the mosque. Obedience to parents appears as a social security strategy to prevent the social risks of a marriage breakdown. She said:

If I had chosen my husband myself and then there was, for example, a disagreement between us until the husband told me to leave; if I go home, they will tell me that it is because I chose my husband myself. The old people will say that they wanted me to marry a different person and I refused, so my problem only involves me. But if they choose my husband, and then there is a problem between us, they will get involved. If there is a problem, they will make us sit together and ask us to forgive ourselves

because that is the way it is. If the old are involved, no matter how serious the problem, you can forgive yourself.

—FTM, 19 years old, Silmiougou, Kaya

The experience of this young woman is not unique—forced and early marriages are common in situations of displacement. The perception of these kinds of marriages, though, differs between men and women in an androcentric and patriarchal society. The reflections of a 59-year-old polygamous husband illustrate this:

Today, you know that the girl and the boy have to get along first before the girl's parents agree to give their daughter in marriage. That's how it was with my first [wife]. My second wife's parents also made us sit together and I had to ask her whether she loves me. If she loves me, they will give her to me in marriage. She said she loves me. Her parents told me to get up and leave. I left and then I was called again. I went and we were made to sit together again and I had to ask her the same question as to whether she loves me. She said again that she loves me. They told me to leave. I left and I was called a third time to sit together with her and ask the same question and she said yes again. They told me to leave again and I left. On the third day we were called and [they] gave away their daughter to me in marriage. And all without lying to you, when my second wife's dad wanted to give me his daughter, I didn't believe it. He promised her to me when I was young and only 40 years old. He told me to do everything to marry her because he himself had six wives. He told me not to wait to marry until I could afford it, only because it is God who gives the means. I then agreed to marry the girl, and here she is with a child.

—Husband, 59 years old, Pissla, Kaya

This story suggests that the marriage required the young woman's consent. However, his 20-year-old wife provided a different view of the union:

[LOW VOICE] It was my father who gave me away in marriage. [TEARS IN THE EYES] I didn't want to, but he had already given me away in marriage. Although I had someone I loved, my father refused because he had already promised me to someone. If you were promised as a child and when you get older, you decide to marry another person, he does not accept that. With my co-wives, we don't get along so much, [laughs] because of the rivalry only. There is no one with whom I get along at all.

—FTM, 20 years old, Pissla, Kaya

Similarly, another young woman broke down in tears during a focus group discussion in Pissla at the question of whether she had chosen her husband. Her crying in front of peers underscored the psychological trauma of forced marriages for many women. The pervasiveness of forced marriages is emblematic of GBV as well as other types of violence that women suffer daily in terms of lack of respect, neglect and devaluation of women—types of violence so routine that they become banal.

Some men who participated in the study also related how they were forced to marry their brothers' widows at a very young age. In Pissla, a 46-year-old man told his story of being married to three women, the first of who is 57 years old and the widow of his brother. All three of his marriages were arranged by his parents.

The persistence of customary marriage practices is also accompanied by prohibitions of alliance between certain castes in the Kaya region. For instance, the "yarcé" and the "blacksmiths", the "yarcé" and the "Peuls", the "nyonyonsé" and "the Peuls" cannot marry one another. This prohibition is built on inequalities and discrimination of individuals according to occupation and nobility in traditional societies.

Love or Free-Choice Marriage

However, forced marriages appear to be declining in the communities of Kaya and Fada. According to study findings, increasingly, apart from the most remote villages, forced child marriage is no longer common. A national "Don't call me Madam" campaign was launched in Burkina Faso in 2018 to reduce child marriages. According to these MILs:

We no longer give [children] in marriage, as the children of this era do not agree; we don't do that anymore. When they meet and love each other, the girl will say, "I love you but you have to go to my father's house, ask for my hand, if it's serious then we'll have the wedding." This is how marriages are contract. In the past we gave in marriage. If you give in marriage and she doesn't agree she will say that it was her mother who gave her in marriage. If she chooses her husband, we celebrate their marriage, and she and her husband are responsible.

—MIL, 50 years old, Boulayaogin, Fada

What was recommended first by tradition was that people gave the girls away in marriage. But these days, we don't give children away for marriage anymore. So it's the boy who meets the girl and he introduces himself into the family. If the parents agree, then you can get married.

—MIL, 48 years old, Pissla, Kaya

Rather than entering forced or arranged marriages, more young people seem to be engaging in romantic encounters in markets, at boreholes, or during festive ceremonies, and as a result, they seem to be choosing their spouse before going to the parents for validation. Marriage is not yet an individual choice for either the man or the woman; even if the two meet within their social network, the family's validation

of the choice is critical. This power of parental consent remains an important component in the definition of marriage.

Marriage is understood not by the choice of a spouse to form a couple, but much more by the agreement between two families consecrated by traditional rites. Hence, even free-choice marriages do not exempt young people from giving the bride price (*poug-poussum*) and the rite of giving the girl in marriage in exchange (*poug-siouré*) that are prescribed by custom and tradition. It is worth noting, too, that forced marriage and traditional marriage are perceived differently, in that the latter gives control of the couple to the families of the bride and groom.

As far as unions are concerned, before we gave [away girls in marriage], or we forced you to marry. But now young girls choose their husbands and young boys also choose their wives. So that's what we see here in Diabo. Otherwise, forcing to marry as was done before here is rare. Before it was an exchange: you give and I give. It was friendship and for the respect of friendship, I could give away in marriage even if the child does not agree. We forced her to go, but currently we see that there are "PPS"¹⁸ that are done here, we do "furi"¹⁹ we do marriages.

—Male CHW, 50 years old, Diabo, Fada

Even if you get married at the town hall or elsewhere, at home anyway, whether the wedding is done at the mosque, in the church or elsewhere, with the wedding rings and all the amenities that go with it, as long as the traditional rite with the slaughtered chicken is not done, we do not recognize you as a woman of the family. You are only one individual. And right now when a problem arises, the family is not involved in its resolution. But once the chicken is slit you become the wife of the whole family.

—Male CHW, 23 years old, Pissla, Kaya

Although the data suggest that the way young people are entering into marriage is changing, the different forms (forced, arranged, traditional, free-choice) of marriage coexist in the study sites. FTP couples with "love marriages" seem to be characterized by a smaller age gap between wife and husband when compared to couples in arranged marriages and are sometimes of school age. However, social norms still dictate that the man should be older than his wife, as he is considered the authority of the family.

¹⁸ This is the traditional marriage called *poug poussum* in Mooré, which young people call PPS.

¹⁹ Muslim marriage

The woman from time to time needs to be guided, and you may not be able to deal with certain situations. But if it turns out that she is older than the man or that they are of equal age, the man's instructions will not be respected. Often, this is why the woman will say that the man is not her elder and it generates marital conflicts.

—Female CHW, 33 years old, Pissla, Kaya

Some MILs seem to deplore the free choice, which they believe leads to conflicts between young people in couples because of poverty.

Our sons do not get away with it financially when with a woman. Often, we provide some of the needs of our grandchildren. All this rushing into marriage among students—there are many of them right here. You don't have a job and you're getting married! We are the mothers who suffer at the end.

—MIL, 43 years old, Pissla, Kaya

The Purpose of Marriage

In this study, the role of marriage in human reproduction is central to the definition of a couple, regardless of the type of marriage. Findings suggest that marriage only makes sense if it is accompanied by the birth of a child. During the interviews, FTMs and their husbands were unanimous on this opinion.

You were alone, and after the marriage, there are two of you. Later, you are five. That is the advantage of marriage—your family grows over time. If you're not married, you can't have all that. What can bring happiness into the family is when you have children in marriage. This is what can bring happiness.

—Husband, 21 years old, Tibga, Fada

If you get married and you can't have a child, there's no joy, and so that's a challenge. What can bring happiness in the couple is when there is agreement in the couple, there is health in the family, and you have children. This brings happiness in the couple.

—FTM, 25 years old, Moadá,

As in many traditional societies, there is an expectation that children must care for their parents, who have also taken care of their own parents. Study respondents noted that marriage allows the necessary continuation of this cycle of social debt.

When the parents who gave birth to you are tired, you are the one who has to take care of them until they leave this land. It's like a credit you took. You have to pay it back. When they gave birth to you, they did everything they could to help you grow up. So you, too, have to be able to get married and have children who are going to grow up, and that will be beneficial to both of you. That's when you would have paid off your credit. The benefit for the wife is that when the wife's husband is alive, she does not

understand the importance of children. It is when the husband dies that the wife will see the children's importance. The children will be blessed and they will take good care of their mother and even their family members....The advantage is the children. Despite whatever else you have, it's the children that are more important.

—Husband, 51 years old, Silmiougou, Kaya

B. Gender Norms Among Couples

Recognizing the strong influence of social and gender norms on the dynamics of power in couple relationship, the study aimed to identify the norms that are prevalent in FTP marriages in Burkina Faso to help inform the design of CFIs that promote joint communication, shared-decision-making, as well as women's bodily autonomy with respect to family planning.

In this study, participants were asked to describe their notions of “a good wife” and “a good husband” to help investigators understand social expectations of men and women's roles in marriage relationships. Their perspectives highlight the gender norms that undergird the unbalanced expectations and limitations places on married husbands and wives.

A “Good Wife”

According to study findings, a “good wife” is defined on the premise that women have a lower social status in society, and requires passivity, exemplarity, and a good attitude from women. In the words of one polygamous husband:

In a village, a good woman is the one who respects the words of her husband. The one who takes good care of strangers even in the absence of her husband—she's a good woman. Also, for example, if you fight at home and you see that there is visitor who says Salama alhekoum,²⁰ she stops the fight. If the visitor enters the courtyard, he won't know anything [about the fight]. That's a good woman.

—Husband, 51 years old, Silmiougou, Kaya

Another man, however, offered a similar viewpoint but recognized the unrealistic expectations placed on women, acknowledging that there is no perfect person:

I can say that a good woman is one who does not like shame, who respects people. That's what I think. But no one is flawless. Sometimes people say that someone is good, but then her behavior spoils everything. There is no one who has no defect.

—Husband, 46 years old, Pissla, Kaya

Many of the women themselves in the study seem to have internalized these expectations of behavior.

²⁰ Muslim greeting

During an interview in Diabo, a young FTM, 18 years old with a young child, declares “a good woman means the one who does not speak, she does not provoke, she only does her job.” This understanding of a “good wife” is associated with limits to a woman’s ability to speak, both in the family and in society. The interviews underscore the belief that a wife is considered an outsider to the family, and as such should not insult or disrespect her husband or any member of her husband's family, nor should she meddle in family affairs. During a focus group discussion, one FTM lists the excluded areas in which women are not allowed to speak:

There are subjects that are not the woman’s responsibility; for example, if we want to talk about a girl's marriage, when the family sits down to discuss it, the woman has nothing to say in it. The wife has no say unless the husband is absent. There are family topics that do not concern women.

—FTM, 21 years old, Bilentenga, Fada

These MILs from Fada also maintain:

If this is a problem related to the man's family and not the couple, the woman has no say in that because she is not at home in her native village; if she gets involved, she'll end up having problems. So she can't get involved.

—MIL, 55 years old, Moadaa, Fada

The woman cannot say anything in the house due to the fact that the woman comes from another family. So in the family discussions she cannot say anything.

—MIL, 53 years old, Tibga, Fada

The legitimacy of a woman's word in the family also is based on fidelity to her husband. A virulent discourse on the infidelity of women appeared throughout the interviews with the male study respondents. While a husband’s infidelity is socially acceptable, a woman’s infidelity is associated with bad luck, communication difficulties, a break in the relationship, and for some husbands, the reason for refusing to use a contraceptive method. Below is an excerpt from a focus group discussion with male CHWs in Kaya district:

Male CHW, 45 years old: *But if it's a man [who is not faithful to his wife] it's less serious because it doesn't bring any bad luck to her husband. Most of the time, it is a woman's infidelity that is most decried. When a woman launches into adultery, it is the family she wants to break up. That's why people don't tolerate it at all.*

Male CHW, 27 years old: *Two women can share the same husband, but two men cannot cohabit with a woman. Tolerance of a man's infidelity is rooted at this level. If the woman commits adultery, the*

gods will hold the man to account. But if it is the man who commits adultery, no account is asked of the woman. It may be shameful for man, but that's the only punishment.

Male CHW, 30 years old: *What do the ancestors' spirits not condone? If the woman commits adultery, whatever her lover has given her, whether it is money or food, she must do everything to prevent it from coming home. Because the spirits are going to say you, man, you're sitting and your wife is going out to bring impurities home; right now they can cast a spell on you like paralysis of the legs, loss of sight, or any kind of supernatural illness incomprehensible by ordinary people.*

Though of different age groups, these men expressed similar views about women's infidelity. This sort of prejudice about a woman's sexuality fuels a form of routine violence against women in their daily lives. It is also worth noting there was relative silence with regard to the infidelity of men during the interviews and focus group discussions with female study respondents, suggesting that many women have resigned themselves to the weight of the social norms of masculinity.

In terms of a wife's role in the marriage, she is the person assigned to household chores: preparing food, washing clothes, and maintaining the yard.

Normally the woman must prepare food, ensure that her husband's clothes are clean, sweep the yard and maintain the houses. This is what is normal.

—Husband, 51 years old, Silmiougou, Kaya

The first thing a woman has to do when she wakes up is clean her house, sweep the yard, and do the dishes. After the dishes, she has to wash [clothes]. After finishing the laundry, she has to fetch water. After getting the water, she prepares food to give people to eat. After that, she can do her business.

—FTM, 19 years old, Silmiougou, Kaya

A “Good Husband”

In contrast to a “good wife”, interviews with both male and female study respondents reveal that a “good husband” is one who provides for the needs of family members and embodies the values of leadership, forgiveness and courage. FTMs defined a “good husband” as someone who can provide food needs, build a house, and take care of the schooling of his children.

I think a man is said to be good when he is trying to solve the problems of his family, who accepts everyone and who makes his family's problems his problem, who has good relations with the neighbors, and who does not like fighting. I think that's a good man. He is also the one who has no problem with his family, children and women. The one who doesn't look for a problem with anyone. I think if someone meets these criteria, one should consider him a good man.

—Husband, 46 years old, Silmiougou, Kaya

A good man is the one who accepts forgiveness. He is the one who accepts forgiveness when he asks for forgiveness. He is a good man who can be a leader.

—Husband, 51 years old, Silmiougou, Kaya

The responses of young couple members were no different from those of the older generation. Both highlighted the husband's role as caretaker of the family's social and material needs, including health care. However, this role seems to be evolving, mainly among younger couples, to one that is more complementary and shows mutual assistance.

Yes, I agree to sweep the court. It's me, I said I love her, we don't have to let her do the work alone. When they see you sweep the yard, there are some people who will go and say nonsense to others, that the woman acts in such a way [dominates]. There are others who encourage you. But we think it's that we love each other. So it's my duty to help her do some work. She also helps me sometimes with some chores. Just because I'm helping her doesn't mean she's forcing me. I'm the one who decides to help her do some work. If you're going to marry a woman and tell her to do all the work alone, it's not right.

—Husband, 33 years old, Pissla, Kaya

It is to take care of her husband and children so that there is joy in the family. Whatever the man says [to do], you just obey. You help each other for example by taking care of the children, whatever chore there is in the house, you help each other.

—FTM, 25 years old, Moadá, Fada

A 21-year-old man from Tibga (Fada) adds that a redistribution of tasks in the couple is likely to improve communication in the couple “because if you want the current [i.e., communication] to flow between you, the sharing of tasks must be fair. Then, there will be no conflict.”

However, when analyzing the responses about the daily routines of the FTMs in the study, the "traditional" roles of men and women persist even among the younger couples. The women remain busy with multiple tasks, often needing to get up at 5am and completing their responsibilities late around 9pm, especially during the rainy season. The only time women have to rest is at night when they go to bed.

C. Factors Influencing the Dynamics of Couple's Communication about Family Planning

The gender norms described in the previous section underpin whether and how couples communicate with one another about topics related to family planning and reproductive health. In this study, investigators aimed to pinpoint specific factors, either barriers or facilitators, that influence these dynamics of communication within a couple and that could potentially be leveraged to design feasible and relevant CFIs.

Place and Time for Couple's Communication

The term “communication” appeared to have a dual meaning in the local language when referring to couples. One meaning referred to a discussion or dialogue between the couple members, while the other referred to the act of having sex. This duality could explain the discomfort of some study respondents when asked to address the topic of couple's communication. Given this understanding, communication between couples is considered intimate and assumed to only take place in private spaces when couples are alone.

When it's just the two of us, we can talk. I won't be able to answer that question, eh (laughs). Really, here, I will not be able to answer.

—FTM, 25 years old, Moadá, Fada

In the courtyard it is possible to talk about it [sex] but he may disagree if our ideas diverge. But if you are in the room, you two can find ideas that converge and use it to help you in the future.

—FTM, 21 years old, Bilentenga, Fada

Study findings highlight that couples communicate about intimate matters when they have time and space that offer privacy, which is not easily attainable for many couples, and a willingness to talk among both spouses. Women testified to their very busy daily schedule, especially in the rainy season.

In the morning, I get up and go to the field. I go to work and come back to prepare [food] for my children and my husband. At night, we meet to talk and when it is time to go to bed, everyone goes to bed. We get up very early. Often it's 5am, sometimes it's 3am...it's often 8pm [when] we go back to bed.

—FTM, 25 years old, Moadá, Fada

In this context, and particularly in a region where husbands are absent due to work or displacement, finding a good time and space to discuss intimate subjects is not easy.

During the rainy season there is not enough time [to talk] if it is not around 5pm. Then we can sit down to talk a little in the shed, the shed that's right next to our house.

—FTM, 19 years old, Silmiougou, Kaya

My husband and I are not together at all times. My husband is in Ouaga and I'm here. So if you're not together all the time, it's hard to talk about that [FP] at any time.

—FTM, 25 years old, Moadá, Fada

Since intimate discussions need to be held in the bedroom or other private area, and for many couples there is not that truly private space of their own, then the constraint associated with a willingness of spouses to communicate with each other is easy to understand.

We postpone the discussion to another day, because if the husband is not ready to listen to you, or if the man wants to communicate with you but you do not want listen to him, it is better to talk at another time.

—FTM, 21 years old, Bilemtenga, Fada

Household size also impacts the communication dynamics between husband and wife. Couples typically live in multi-generational households or compounds comprised of the husband's brother and his family, in-laws, and in polygamous families, the co-wives. A full house makes finding a private time and space for couples to communicate very challenging.

If there are many people in the house, we are afraid to talk because others might hear. Or if you want to chat, the kids may be close by and can listen. So it's better to leave it until they're asleep before chatting. When there are many people in the house, we cannot talk.

—FTM, 23 years old, Comboari, Fada

When you sit down to talk about family planning, the mother-in-law or father-in-law may overhear, and they don't want us to talk about this. So if you talk, they will criticize; or you decide to use a method, and then later you want to have a child and you can't, they're going to talk. So it's better to leave it until it's just the two of you to talk about family planning.

—FTM, 22 years old, Moadá, Fada

During one interview, a polygamous husband recounts how he communicates with both wives simultaneously, which clearly reduces the space for private discussions with an individual wife and is not

conducive to more intimate communication within the couple. The data suggest that monogamous couples are more likely to communicate more freely with one another not only because they have chosen their partner but also because they tend to have better access to private space.

Interviewer: *Are you chatting with both at the same time or is it separate?*

Husband, 51 years old, Silmiougou, Kaya: *No we sit together chatting until we are sleepy and the one who has to stay with you stays and the other gets up to go to sleep. The next day, we sit together and talk until we are sleepy and the other also gets up and go to sleep.*

Words and Silences of Couples

During the study, interviews were used to explore whether FTMs and husbands communicate about matters related to health and to sexuality. It was clear that FTP couple members did not feel comfortable raising the topic of sex with their spouses.

We got married and we don't talk about sexuality (laughs) because that's the main subject [of our relationship].

—Husband, 46 years old, Pissla, Kaya

When we talk about sexuality and he refuses to talk because I tell him I want to use FP, in these situations he changes the subject and talks about health. If I say I want to use FP and he refuses to talk, yet he wants to look for other women outside [the marriage], you see that it cannot work.

—FTM, 20 years old, Diapangou, Fada

However, intimate topics related to sex such as fertility intentions, birth spacing, and even sometimes family planning were discussed by some couple members in the study.

I told him that I would like to have a child this year, and then I want to wait another four years to have another child. This discussion was helpful...

—FTM, 25 years old, Moadá, Fada

We are discussing about family planning. I tell him [another husband] that he who uses family planning, his child will grow up in peace [good health] and he himself will be able to rest.

—Husband, 30 years old, Boulyaoguin, Fada

Investigators observed from the study data that women were more likely to communicate about health issues, including FP and birth spacing, though they seemed to express reservations about the image of women who do discuss these matters. Limiting or choosing the number of children is not a priori the most commonly mentioned topics. A paradox is that the topic of family planning and birth spacing can be

discussed, but not the number of children. In some communities, one predominant belief is that the number of children is never counted, at the risk of attracting bad luck or misfortune; the child remains seen as a gift from God. As such, speaking about plans or desires for a specific number of children is discouraged, while spacing births is considered a more acceptable topic of discussion.

FTM, 19 years old, Silmiougou, Kaya: *Ah, what I want is four children.*

Interviewer: *But did you say that to your husband?*

FTM: *No, I haven't spoken to him yet and I also don't know how many children he wants to have. But the number of children he wants to have is the number I also want.*

What we want is for God to bless the children. If he gives you one or two children, bless them. We want God to give us the number of children he wants us to have and to bless them. Otherwise if you try to choose the number of children you want, God will not give them to you.

—Husband, 59 years old, Silmiougou, Kaya

In addition, a common assumption held among husbands in the study is that if women are not able to keep secrets, husbands then must distinguish which subjects he is able to communicate about with his wife. The uneven power dynamics and the double standard reflected in the study data highlight the obstacles presented to intimacy and good communication within a FTP couple.

There are some things that really cannot be said. There may be a problem in the family that you cannot tell the woman because a woman is only a woman. You can tell her something and the day you are not around, she'll tell others. Because if it's a family matter, I talk to my brother—I can't tell the woman. The talk must stay between the two of you [with the brother]. If you tell the woman, it can cause problems one day.

—Husband, 21 years old, Bilentenga, Fada

Harmony in the relationship

Intimate communication within the couple is influenced by the presence of disagreements and conflicts of various kinds. According to one husband:

What will make difficult to talk is when one person says to do this and the other says no. If there's that, you may want to tell her something but you are afraid that she will refuse. If you sit down and try to figure it out yourself, these worries can fade away. If you can sit down and be able to say that at this level I am at fault, then you can discuss it right now, saying you had a fight and now it's over— let's look to the future. But often there is a lack of understanding.

—Husband, 27 years old, Moad, Fada

Disagreements sometimes concern other members of the family. Monogamous couples were believed to be more likely to find harmony in the relationship, as co-wives were often cited as a source of tension in the polygamous couple.

If it's a monogamous couple, the husband can join his wife to talk without problems, but for a polygamous couple, if the husband chats with one wife and does not pay attention to the other, it leads to arguments.

—FTM, 19 years old, Silmiougou, Kaya

Often my co-wife can do things that I don't like and we [the couple] quarrel. Also, often your mother-in-law can say you did something she didn't like.

—FTM, 20 years old, Pissla, Kaya

According to the respondents, another cause of couple discord is a wife's lack of understanding for her husband, placing the responsibility of family harmony squarely on her shoulders. An accusation of not knowing her husband and in-laws hints at the belief of a woman's foreign status in the family.

If the wife does not know the character of her husband well, you cannot get along. If she doesn't know your character, whatever you're going to give her as advice, you're never going to get along.

—Husband, 51 years old, Silmiougou, Kaya

In addition, suspicions of a wife's infidelity toward her husband is common source of conflict mentioned by study respondents. In the study villages, male infidelity is considered normal while that of women is severely condemned.

If she has it in her head that you have concubines outside, then the problems cannot end.

—Husband, 51 years old, Silmiougou, Kaya

Finally, study findings suggest that marriage problems are inevitable when a couple is not able to have children. This too underscores the responsibilities that women bear to have children, which is believed to be critical for harmony to exist in the marriage and family.

The difficulties in marriage, in my opinion, occur if you get married and you can't have children because if you can't have children, there is no joy, and that too is a difficulty. If you cannot have children, you and your husband have no agreement. It's a challenge.

—FTM, 25 years old, Moad, Fada

The Mooré term *woumtaaba*, meaning “to hear”, was used in several interviews to describe a key factor in couples’ dialogues that allows discussions about contraception and facilitates a couples’ arrival at a consensual choice of a contraceptive method.

In my opinion if you love and respect each other, there will be good understanding [between you] and you should know how to speak so as not to offend the other. In this case, if you’re together, there’s laughter and joy.

—FTM, 21 years old, Bilentenga, Fada

If there is agreement and you love each other, it is easy to communicate. You can then chat about anything. But if there is no agreement, it is difficult to communicate. As there is no joy, it is not easy to be able to talk.

—MIL, 57 years old, Pissla, Kaya

D. Factors Influencing FTP Couples’ Decision-Making about Family Planning

As with couple’s communication, the study aimed to determine the specific influences, often supported by gender norms, that either impede or support shared decision-making among FTP couples. Investigators believed that identifying these factors was critical for understanding the language, skills or other tools that may be needed to support a more balanced power dynamic in a couple’s decision-making about FP.

Focus on Benefits of FP for Family Health

Study findings show that the FTP couples in the study who were using contraception did so primarily considering the health benefits not only for the mother and child, but for family life. These statements also point to the shared belief that children are central to both the marriage relationship and the continuation of the family lineage.

FTM, 21 years old, Pissla, Kaya: *We thought we should use contraceptive products or we will get pregnant while the child is still small. If you get pregnant when your child is still small, it can affect him. He can get sick. But if we space [the pregnancy] for three or four years, he’ll be big.*

Interviewer: *But did he [husband] agree that you should go and choose a method?*

FTM: *Yes*

I tell him that he who uses family planning, his child will grow up in peace [good health] and he will be able to rest.

—Husband, 30 years old, Boulyaoguin, Fada

The fact is that the issue of health has become very worrying today. When the births are too close together, the woman is overloaded; she cannot do her business because she has to take care of the children who are still too small. The man also does not have the time regularly to help her to take care of the children. On the other hand, if there are at least four years between the two children, the first is big enough to go and play with other children. The mother can then wear the smallest on the back while attending to her work. And you will see that the children will be healthy.

—Husband, 46 years old, Pissla, Kaya

If you give birth this year and wait four years for the next pregnancy, you are healthy, the child is healthy, and the husband is healthy too. But if you give birth close together there is suffering. This was important because after my first child, we didn't want to have second child for another three years or four years.

—FTM, 25 years old, Moad, Fada

Husband's Role

Given the androcentric and patriarchal context of the study villages, it was not surprising that findings clearly show the husband holds the decision-making power on whether his wife uses contraception.

For birth spacing, it is my husband who gives permission.

—FTM, 25 years old, Moad, Fada

I think that it's better if it is the man and not the woman who decides [about using contraception]. Because often, the man may wonder why the woman wants to use family planning. What exactly does she want? But if the man tells the woman to use family planning, it's better! Because he is the head of the family.

—Husband, 29 years old, Comboari, Fada

Interviewer: *In your family, who can make these kinds of decisions [about family planning]?*

Husband, 21 years old, Tibga, Fada: *Here, it is the husband who decides.*

Interviewer: *Why is it him?*

Husband: *Because you're the head of the family, that's the way you want things to be done...*

Interviewer: *Do you think your wife can decide to use family planning on her own?*

Husband: *I don't think she can do that.*

The husband's role also extends to the selection of the contraceptive method itself.

Interviewer: *What is your [contraceptive] method?*

FTM, 21 years old, Pissla, Kaya: *It's for five years.*²¹

Interviewer: *Why did you choose for the five years and not for the three months?*

FTM: *It was my husband who told me to use this.*

The husband's decision-making power is rooted in the social norms around the notions of a "good wife" and "good husband". Thus, a woman who goes against these norms to make an independent choice to use contraception risks facing social consequences.

Unless you're going to hide to [use contraception]. If we knew, too, you're dead. We can even repudiate you. We will say that you want to look for other men; even if we were to forgive you, your mother-in-law can kick you out of the house.

—FTM, 19 years old, Moadá, Fada

One of the reasons why women play a subordinate role in making family planning decisions is linked to the assumption that women using contraception are not faithful to their spouses, leading to conflict in the marriage. This is especially reflected in the statements made by the male respondents in the study.

Because if my wife does this [uses contraception] without informing me, it can create disagreements in our relationship. Because I can say that it is no longer me alone who is with the woman. She's with everyone now.

—Husband, 21 years old, Bilentenga, Fada

The woman is not allowed to use these contraceptive methods without her husband's knowledge. I think she has to consult her husband first because when she goes looking for it discreetly, and then there's a problem, for example, a disease you can't hide. You can go and get it [contraceptive method] and it's going to cause illness. Can we hide a disease?

—Husband, 46 years old, Pissla, Kaya

²¹ In this setting, providers may assess a woman's FP needs based on how many years she wants to use, and not necessarily refer to a method by name immediately.

Another reason the responsibility for choosing contraception belongs to the husband is related to the payment of health care. When asked who makes these decisions in his family, one husband says:

It's me. Normally it is the man who has to make the decision if there is a problem of illness—after all, I am the one who will deal with it.

—Husband, 29 years old, Comboari, Fada

False rumors about adverse effects of contraception on maternal health, fueled by conspiracies spread through fundamentalist religious discourse prevalent in Burkina Faso and West Africa,²² continue to persist, particularly among men who were less likely to receive information or participate in any FP programs. Husbands' lack of knowledge about contraceptives and beliefs in these false rumors influenced their decisions about whether wives can use contraceptives.

Family planning is a source of disease for women; our mother gave birth to us, six people lived and seven couldn't survive, so it's complicated. I saw women with the Norplant and after [when they went] to remove [it] the nurses did not find the stick. She went to Ouaga and was now returning after trying to get it removed without success. Another [woman] also went to put [in an implant] and after its removal, her first pregnancy sank as well as the second.

—Husband, 29 years old, Comboari, Fada

If a woman gives birth, she should stay six months at her mother-in-law's house so that the child can grow up a little. With family planning, we are told that if your wife gives birth then she goes to get an injectable and stays in her husband's house, that's what gives kids a stomachache. And it makes parents worried.

—Husband, 29 years old, Comboari, Fada

Negotiation and Risk-Taking Among FTMs

Contraception among unmarried girls is not tolerated in the study villages; in other words, contraception can only be used after one or more births. A young woman's journey to adopting a contraceptive method for the first time is primarily forged in negotiation with her husband after the birth of their first child.

At this level, when I decided to have a child, we just got along—he wants a child and I want one too. He was the one who approached me first to talk about it, and I too did not say no. And we decided together to have children.

—FTM, 22 years old, Moadá, Fada

²² According to some Islamist communications, contraceptives aim to make African women infertile in order to help reduce population growth, which would be a threat to the Western world.

This decision to conceive children is made by my wife and me. We can say, for example, at 3 years old, our child is at the age of having a little brother. It is my wife and I who determine the age gap that suits us.

—Husband, 30 years old, Moad, Fada

Based on study data, FTMs seemed to have more awareness about the advantages for FP for herself and her child. Some women felt they were able to introduce the topic of family planning with their partners a result of their participation in the E2A FTP program.

You don't start by talking about that [contraception]. You start talking about Pathfinder [E2A implementing organization] and then you introduce the subject of FP. There, even if he refuses, you can still get along. But if you start talking about FP, he can slap you. We have Pathfinder books. So on the day I want to talk about family planning, I take the book to read. He's going to come and we're going to read together. We read and explain.

—FTM, 22 years old, Moad, Fada

However, many of the FTMs in the study who opted to use a method did so even when faced with resistance from their spouse. A 20-year-old FTM from Diapangou recounted the negotiation process, noting that the discussion about FP took place at night in bed, in the context of the couple's life, the health of their child, sexuality, and love.

I take advantage of telling him what I want and he also tells me what he wants. Since I understand that if we do not space births, the children will not be healthy and I too will not rest. My husband doesn't want me to talk about family planning; when I start to talk, he doesn't listen to me. And if he knew I use a method, he'll talk.

—FTM, 20 years old, Diapangou, Fada

The decisions of these female study respondents to use contraception without their husbands' approval reflect an emerging liberation of women from their husbands' guardianship regarding contraceptive freedom and choice. But these decisions often come with significant social and relationship risks.

One day I told him I want to use FP and he said no and it was a fight. I asked why he says no. I got angry. That's the way it is.

—FTM, 20 years old, Diapangou, Fada

I saw a woman bypassing her husband to come for a contraceptive method, and when she was back home, her husband said she cannot come home. In any case when there is a common decision, it is better.

—Male CHW, 29 years old, Pissla, Kaya

I've seen a woman who decided [to use FP], but it was a problem afterwards. Her husband threatened to repudiate her.

—Male CHW, 29 years old, Pissla, Kaya

The stories from the young FTMs using contraception without their husband's approval are not marginal, as more and more women are taking the risk of using contraception despite opposition, sometimes in secret.

You may want to do it but your husband does not agree; you can even go and do it in secret, but he'll make you remove it afterwards.

—FTM, 21 years old, Pissla, Kaya

Sometimes we learn that a husband touched his wife's arm and found something there. It becomes a fight and most of them come and have it removed. We see women hiding their notebooks to come [for FP services] but it is not good.

—Health provider, Kaya

Secrecy and Shame Surrounding Contraceptive Use

Findings from this study suggest that the use of contraception is considered a couple's secret and the disclosure of which is considered a source of social shame in rural communities. The decision-making process, then, to use contraception is weighed down by the couple's need to keep it a secret and the risks they take should knowledge of a couple's use of contraceptives were revealed, either to friends, other family members including MILs, as well as to the general public.

It's a couple's secret. You agreed together to use FP, and even if there is a problem, you must not let the secret leak. You have to find the solution internally, with the help of health workers to overcome the problem.

—FTM, 21 years old, Bilentenga, Fada

Now, if it happens to be family planning, it is complicated because our parents do not even want us to talk about it in front of them. If you want to pursue this subject, they will lecture the husband to say that it is not possible.

—FTM, 21 years old, Moadá, Fada

People see methods as something shameful...Even the women who gather together, they say “ah, I use a contraceptive method”—no, you will not see this happen during the talks even between them.

—Husband, 59 years old, Silmiougou, Kaya

For those couples who do use FP, their secret must be shared with health workers, including CHWs, who offer the contraceptive methods. These providers are then bound to also keep the secret.

In terms of FP, it must be a secret. As a CHW, if you venture a guess and then the wives, the brothers' wives, and the old [mothers-in-law] learn the secret, you won't even be able to drive around town. Words like "they use FP, they don't want any more children," everywhere you go, you get that label. If by chance the contraception you use causes delays or health problems, no one will sympathize or help you. So it must be a secret between the couple, and you [CHW] have to do everything to keep [it].

—Male CHW, 30 years old, Pissla, Kaya

One female CHW incriminates other females for their role in gossiping and spreading falsehoods about couples using contraception.

We women are the ones who create the problems. The husband can agree on the use of FP. For example, when Marie Stopes came to offer these services, there were husbands who accepted that their wives use them. But the other women will see and spread this [information] in the market and throughout the village. At the slightest illness, we will say that it is [because of] FP. Any woman who uses FP, as soon as she gets sick, they blame the FP. Even if it's malaria.

—Female CHW, 33 years old, Pissla, Kaya

E. Role of Mothers-in-Law in Couple's Communication and Decision-Making

E2A's FTP program in Burkina Faso included the implementation of group-based sessions with family members, namely mothers and MILs, to build support for positive health actions among FTPs. Based on this experience, the study aimed to understand how MILs affect FTP couples' communication and decision-making practices in particular, in order to better structure and target effective interventions that engage these key influencers. Study findings indicate that from their perspective, MILs are often given the task of mediating couple conflicts and therefore facilitate communication between the couple.

If there is a conflict between two partners, the woman must look for a trusted person to whom she will expose the problem, so that the person can come to her husband and ask for forgiveness and so that peace will return to the couple.

—MIL, 56 years old, Pissla, Kaya

What the mother-in-law can do is call the man to talk to him. Then you're going to explain everything to him. If it is a child who is sick, the mother-in-law can call the man. She can even pick up the child and take him to the hospital. I'm not going to let the child die.

—MIL, 43 years old, Pissla, Kaya

I start with my child and figure out if he is right or not, then I advise him before talking to his wife. Because if you start with your daughter-in-law she can send you back to your child. If there are arguments, you start by calming the situation, then you talk to your child and make him understand that he must live in the same way that I lived with his father.

—MIL, 53 years old, Moadá, Fada

The MILs suggest that their role is more important in situations where there are disagreements between husband and wife, seeing themselves as effective mediators of couple conflicts.

Otherwise there are women who are afraid of their husbands. So these tips help a lot. We talk to them because we know it will help them a lot.

—MIL, 48 years old, Tibga, Fada

However, other opinions emerged from the interviews that differ from the MILs' perspectives, noting that MILs can be the source of tension within a marriage and do not want to hear about family planning.

Often your mother-in-law can say you did something she didn't like.

—FTM, 20 years old, Pissla, Kaya

Go tell her [mother-in-law]? She's going to tell you to go with your denunciation and your current world practices. "We gave birth to more than a dozen children without planning—aren't your husbands alive?"

—Female CHW, 48 years old, Silmiougou, Kaya

While it's clear that the husband is the primary decision-maker about health issues, family members can still influence decisions. In a social structure with hierarchies built on age, the in-laws, particularly the mothers-in-law, play an important role in the health decision-making process.

It is the mothers-in-law and fathers-in-law who decide on these [health] issues. For example the child is with you and if the child is sick you can approach the mother-in-law and explain and she will help you, you will come to the hospital to look for the tablets. If the mother-in-law is not there, there is the father-in-law or husband.

—FTM, 25 years old, Moad, Fada

Again, MILs participating in this study credited themselves as a positive influence on a couple's decision to use contraception when they recall the benefits of FP and give advice to young couples or accompany them to health services. The traditional role of MILs as the older women in families extends to health care-seeking practices among FTPs and their children.

If you give birth every three years, the child will be fit and the mother will be in good shape too. And when it's like that, the child doesn't suffer, the woman doesn't suffer, and the mother-in-law also doesn't suffer. We can accompany him, and even if the husband wanted to refuse, he will not do it anymore because it is for his good too.

—MIL, 43 years old, Tibga, Fada

If a woman is pregnant, it is you who must accompany her to the hospital. If it is ANC, it is you who accompanies her. If it is childbirth, too, you must accompany her. So that's also the tasks of the woman [mother-in-law] in the house.

—MIL, 48 years old, Tibga, Fada

For our part, it is to take care of the children and the daughters-in-law. We have to scramble to feed all the kids. A child who is sick, it's us who watch [him]. We will take him to his father and explain to him that the child is sick and we want to go to the hospital. He will give us his point of view before we bring him.

—MIL, 63 years old, Tibga, Fada

F. Acceptability of Couple-Focused Interventions

Through this study, investigators examined whether programs or services that target the couple as a unit would be considered appropriate and acceptable by those who would receive couple-focused interventions (FTPs) and those who would deliver them (CHWs and providers). Recognizing that CFIs have not yet been implemented systematically in the study areas, we looked at what study respondents believed CFIs are, what their potential benefits might be, and whether FTPs would participate in CFIs. The health providers interviewed in this study were not familiar with the concept of CFIs, with one nurse admitting he did not know the term at all. Most of the respondents surmised that CFIs focus exclusively on the couple.

For me it is an intervention that ... allow[s] a certain harmony in the couple and in any case perfect the relationship in the couple to improve the demand for FP and maternal and child health services.

—Health provider, Fada

A couple-oriented intervention is an intervention that revolves around the couple, especially the problems that affect this couple, the consequences of this problem, and perhaps the solutions to this problem. Apart from that, other outsiders will not be part of the couple and do not need this intervention. It only affects the couple.

—Health provider, Fada

In contrast, a few study respondents indicated that CFIs should not be focused on the couple, but on the family as a whole.

It's not just the wife and husband, but there are children as well. At the beginning we can say that it is the wife and the husband. And then there are the children who come. But you can't involve the in-laws in the couple. In the couple, it is the man, the woman, and then the children.

—Health provider, Fada

A district manager provided the following, broader definition:

This refers to all the contributions that can be made to the couple in all areas. It could be in the health field or the economic field.

—District manager, Kaya

In terms of experience with CFIs, some providers referred to HIV/AIDS testing. A midwife says:

At our level here, we screen women for HIV. We hand them flyers to give to men; even those [women] who come for FP, we screen them [for HIV] and we hand them flyers to tell the men to come [for HIV testing]. I believe that at this level we can take advantage of doing the test and profit from chatting with him.

—Health provider, Fada

More and more, women are being asked to be accompanied by their husbands. And even in the context of screening when we see serodiscordant couples or couples who are both HIV positive, treatment is not the same as when someone who is sick or who does not carry the disease. Therefore, there are many actions that are carried out that must be centered on the couple and not on the individual.

—District manager, Fada

Based on their understanding of CFIs, all health care providers interviewed were unanimous on the potential benefits associated with implementing CFIs. These benefits go beyond the couple and reach all aspects of family life. A district senior team member highlights the benefits while insisting on maintaining the gendered division of tasks in the family in these terms:

I think it's going to benefit a lot. When we put the couple in front of their problems, I think everyone will know how they are going to make life better. There are couples where they don't know exactly what their role is. But if there is an intervention, understanding everyone's role in the couple, even in relation to children—what the man should do, what the woman should do—will be beneficial for the whole population.

—District manager, Kaya

Some of the health providers recognized the potential for CFIs, noting that providing joint counseling for couples enhances the transparency of the information shared and avoids misunderstandings between the couple members about the reason for using contraception, thus facilitating communication and the decision-making process.

I think that if we introduce the husbands, our words won't be in vain—there will be more understanding because if you are talking to a woman here, and her husband knows nothing; when she gets home, she's going to talk to her husband who won't even listen to her. I think if both are aware of the case, it's going to make work easier.

—Health provider, Fada

For example, you [CHW] are a man and you're here to let the gentleman go and talk to the woman. Ah, you're telling the woman to use family planning. What is the proof that what you're saying to her if she's using family planning, it isn't you who's going to go and have sex with the woman? (Laughs...) So that gives a lot of problems. But when they [the couple] come together and you talk, it gives a lot of advantages and it gives a lot of courage, it even goes well. I find that there will not even be any difficulties.

—Female CHW, 35 years old, Diapangou, Fada

Other study respondents went further to suggest that CFIs could help to increase women's decision-making power by increasing their self-esteem.

If the woman knows the subject, she can give her opinion. Because there are couples where it is only the man who decides; even if the woman has good ideas, the man will say no. He's the one who decides. But if there are interventions like this, it can better accommodate people.

—District manager, Kaya

We notice that in many couples, the gentleman and the lady when they arrive together, even when there is discordance, in the end, the gentleman joins his wife's decision. Most of them when they come together, he listens to her...the woman manages to convince him. (Laughs) She even she threatens, we see that she is comfortable (laughs)...So we can say that it greatly improved the power of the woman within the family, within the couple.

—Health provider, Fada

The FTMs in the study expressed a willingness to participate in activities and services organized for couples. One of the reasons for this willingness is a recognition that joint participation can help to increase knowledge about FP for both spouses.

There are those who will get involved and those who will not...For anyone who wants to understand, he'll go! This one too who does not want understanding will not go. Whoever wants to listen to the advice will come; for the one who does not want, nothing can be said. Anyone who wants to understand more about health to take care of himself will come.

—FTM, 25 years old, Bilentenga, Fada

If it is the CHW giving advice and you're sitting down and he [the husband] too is seated, there is no debate; sometimes you can tell your husband something and he will say that's what you want to say; he doesn't believe it's something [that's true], but if he goes himself and the health workers tell him, he too will choose what suits him.

—FTM, 20 years old, Silmiougou, Kaya

Some of the FTMs also affirmed their willingness to participate in CFIs as they see the potential benefits for the couple. In the words of one 18-year-old FTM from Fada, “because family planning helps us, and it helps the child and also the mother of the child.”

G. Male Accompaniment in Health Services

While FTMs and health providers recognized the potential benefits of CFIs and FTMs demonstrated a willingness to participate, this openness to CFIs was not as evident among the husbands in the study. Since CFIs as a broad concept were not familiar to most study respondents, investigators looked specifically at the more familiar practice of male accompaniment in health services as a potential indicator for acceptability. Understanding barriers and facilitators of male accompaniment could offer insights into how to strengthen the approach to engage both couple members in health services.

At the national level, although CFIs are not interventions that are currently being considered within the health department, male involvement in health services is recognized as a priority.

Given the results we have in reproductive health, this has become a priority. This is why we are taking action towards men to have their participation. Initially, it was only women, but there were no results. This is why we involve men.

—Family Health Directorate official, Ouagadougou

Study data confirm that male accompaniment in health services, particularly those geared more towards women such as family planning and maternal health services, is not common practice. In fact, several interviews with study respondents directly state that men do not want to accompany their wives to health services.

There are men who—even if they give their wife permission to go—will never accompany the woman to the health center. They will say that on the maternity side, it is just for women.

—District manager, Kaya

However, findings suggest that husbands are more willing to accompany women for curative care, perceived as a health emergency, rather than promotional or preventive care, especially FP.

Well if it's to treat herself, or if she has stomach aches for example, you can decide to accompany her to go and get treated and understand what's going on. But if it's to get contraceptive methods, I even told you that there are women who do it clandestinely.

—Husband, 51 years old, Silmiougou, Kaya

If she's not feeling well, even though I'm going to ask for my boss's bike, I'll pick her up and take her to a health center. If she feels better, I take her back and go back to where I was. I think it's normal [to bring the woman to treatment] because it's not right to leave a sick woman to go for treatment alone.

—Husband, 46 years old, Pissla, Kaya

If you are sick, it is he who takes you to the hospital. But if it's for ANC, he doesn't expect to take you. If you're not in good health, he can take you. If it is the weighing of pregnancy or the child, he does not go.

—FTM, 23 years old, Moad, Fada

Furthermore, a husband's commitment to accompany his wife seems stronger when it comes to a sick child. This stance is consistent with the importance of the child in conjugal relationships. These husbands admit their involvement in their children's health and seeking care.

We go together if it is the child who is sick. We take the child to the hospital. And this is to help the child regain his health.

—Husband, 23 years old, Tibga, Fada

After my wife gives birth and comes home, if she has to go back to a health center two or three days later to vaccinate the child, I take her myself. The day she takes the child so that he is vaccinated, I take them myself. We normally respect the different weighing times.

—Husband, 29 years old, Comboari, Fada

Some husbands recognize the importance of accompanying their wives to health services, noting that they would be able to receive the same information and advice that their wives receive about health issues that may affect the family. Here, a husband indicates that he has always accompanied his wife to health services, but sometimes his work or other activities prevent him from participating.

It's important, but it's because we just can't. Because when I say it's important, there are people who accompany their wives and continue in their workplaces. If you accompany her, when there is a problem you will understand better than if you stay at home and someone comes to explain it to you. So that helps us all. If you listen to the advice, you can understand something and analyze to find out that it is true, and you do what was advised.

—Husband, 21 years old, Bilentenga, Fada

This same husband justifies the fact that he does not accompany his wife to FP and maternal health services because of his professional activities. He states:

For that, I have not yet participated. No! No! It's like I said. It's masonry [work]. So if she gets up, she takes her bike to ANC.

—Husband, 21 years old, Bilentenga, Fada

This refusal is sometimes linked to local custom passed down from generation to generation (a generational legacy) and expressed in the following way:

Because in the family, if his dad didn't accompany his mom to ANC, he in turn should not do so too. So it's this way of thinking that makes him refuse. They can say that there are women who leave without being accompanied. So you too can go alone like these women do. Often they say it's not even far away, so why should you ask for someone to accompany you.

—FTM, 19 years old, Moad, Fada

Despite this, several FTMs felt that being accompanied by their husbands is very important.

For example, in pregnancy, if the nurse finds that the child's position in the belly is not good, and the man can be given a paper to go and get an ultrasound for his wife. For ANC also, when the child's weight has not increased, we will be shown the foods that it takes for the child to gain weight. So if he's there, he'll understand more.

—FTM, 19 years old, Moad, Fada

If you go together to listen, when you speak, he can't say no because he understands its importance. If you follow each other to go and listen, they'll show you how not to give birth closely together. And if you want to use [contraception], he already knows how it works.

—FTM, 18 years old, Diabo, Fada

This is important because if you go out and listen together, you will all understand its [FP's] importance. He understands it and you the woman also understands. If it is only the woman who participates in these discussions, he can accept [the advice] as easily as he can reject it. But if you both participate, you will both understand and this will help you to space the births well. If we listen together, we'll understand its benefits. Then, back at home, we can share this with the whole family so that those who want to can use [FP] without any problems.

—FTM, 25 years old, Moad, Fada

H. Proposed Strategies for Couple-Focused Interventions

Towards the end of focus group discussions with CHWs and interviews with facility providers and district and national health authorities, study investigators asked what recommendations they had for future program implementers to strengthen husbands' accompaniment in health services and other couple-focused approaches. Their responses focused on familiar service delivery platforms and strategies, but also underscored the need for a holistic approach that reached not only the couple, but also those around them in order to address familial and social influences as well as the health system's readiness to implement CFIs.

Health System Adaptations

Health providers participating in the study noted a need to strengthen human resources in both quantity and quality in order to implement CFIs and accommodate male involvement in health services that are traditionally geared towards women, such as FP and maternal health services. One health provider explained:

For the implementation of these activities, it is necessary to have competent staff. Because if there is a project there, it is even necessary that the health workers on site are complete. Otherwise, it will not be very successful.

—Health provider, Fada

Another suggestion mentioned by study respondents that the health system must do to better accommodate men was to make changes to scheduling and infrastructure at health facilities that would ensure private spaces for couples to receive services.

You have to have a framework that is a bit separate from the maternity ward...when a young couple comes for an intervention and he sees that his mother-in-law is lined up...well you see it's a bit embarrassing! Especially in the village when people see that you accompanied your wife to the clinic, well, by tonight you'll will see an aunt come to find out what is going on. She will ask: is the woman pregnant or she wasn't feeling well?

Now if there is a room where couples can go and get advice or they want an intervention, there is no problem; let them not be with others in the maternity ward that is full of pregnant women for ANC. Now if there's a young couple who just needed some advice for maybe even having a pregnancy, I guess he [the husband] can't go out there sitting down with these ladies.

—Health provider, Fada

It must be said that couples and women are received individually in a room at least away from indiscreet eyes and ears. We know that this is a fairly sensitive subject and there are women who have negotiated to come at night to get a FP method. I think their requests have been granted. We think that people still have the right to keep some privacy in what they do. So I think that in any case we do everything we can to ensure that this aspect is respected.

—Health provider, Fada

One practical recommendation provided by a district manager to help ensure the implementation of CFIs was to incorporate specific couple-focused activities into a district's action plan. This would ensure involvement and support of the district government, while also offering implementing partners the opportunity to buy into or support the approach.

We can even put that in the district's action plan, but if we're not invited, how are we going to know? (Laughs...) You can put the activity in the plan, and now if there is a partner, a partner can come in to support the activity. But now if we are not involved, it will always be difficult.

—District manager, Fada

Supporting and Working Through CHWs

In addition to these health system adaptations, study respondents underscored the importance of building on the experiences of working with CHWs to develop or strengthen a community-based service platform for CFIs.

It must be said that with the CHWs, we work together on everything. How we can help them! We can often help them with advice and motivation. It is in giving advice that they are really working for the community. Epidemiological surveillance is done squarely by them. When there is a case, they report to us the deaths in the community. With the CHWs, we work together.

—Health provider, Fada

One strategy proposed for working with CHWs is to increase their role in communication strategies for social and behavior change, recognizing the potential influence CHWs have in decision-making among couples.

The woman came to me as CHW, explaining her situation to me. I promised her I'd see her husband. I let it go a week and went to see her husband, and he told me that he was actually against the duration of the contraception used which was 5 years. I replied by saying that 5 years is good. But he insisted he would agree to 3 years but 5 years is too much. I insisted that he listen to his wife because she has good reason to take for 5 years.

—Male CHW, 29 years old, Pissla, Kaya

I think the best strategy is communication. I think if we at least involve CHWs in communication on FP, it can really get things done. And if we are lucky, all administrative villages will have CHWs that meet the standards and at least have a certain level. I think if they are involved in communication, it can make a difference.

—Health provider, Fada

However, the health providers in the study noted an overarching need to improve the support provided for community actors if they are going to be one of the primary vehicles for CFIs at the community level.

It is to strengthen the skills of the CHWs, to give them the means necessary to better carry out their activities in the field. Go out and try to see what they're really doing, supervise their actions on the ground, make corrections if necessary, support them as well when possible. They can be supported in awareness materials, posters, picture boxes, inputs. On the ground you also need logistics, not to mention that hey, today you cannot ask someone to do a job without paying for it, so you need financial support.

—Health provider, Fada

Furthermore, the same health provider in Fada stressed the importance of ensuring confidentiality in community-based service delivery.

In fact, you have to take it as if you were doing a medical consultation. We instill in him [CHW], we even tell him when you go into a community setting, whatever you do, always keep in mind that medical confidentiality must be a priority. What the patient has told you or what the couple has confided in you, consider it a secret because if you disclose it...there will be a loss of confidence and it is over.

—Health provider, Fada

Raising Public Awareness about CFIs and Modeling Desired Behaviors

Interviews with health providers also highlighted the use of social and behavior change platforms, such as community theater, radio, and visual materials, to raise public awareness about the benefits of CFIs on family health. Some respondents also proposed leveraging the visibility and influence of public personalities by having them “lead by example” or model joint couple behavior, such as husbands accompanying their wives to health services.

It's about conducting theater performances, sketches, and movies. And choose special people— if there are people who can go to these couples to advise them. We sit for an hour or two and talk to them.

—District manager, Kaya

For the authorities, it's about making firm decisions. If they commit themselves... If we see an authority accompanying his wife, we will say ah, he has spoken and himself is leading by example. At least that sets a good example. But if the authority speaks and you see his wife go to the ANC alone, it's not going to work. If they make firm commitments and lead by example, people will join.

—District manager, Kaya

Why not even audio-visual materials to raise awareness especially in the field of reproductive health? It really attracts people and it also brings young people together with the agents who work in the health center.

—Health provider, Fada

Staying Culturally Sensitive

A few of the study respondents also noted that strategies for implementing CFIs need to consider the social and gender norms of the community and ensure that strategies are culturally sensitive.

There are cultural and social aspects. It is true that there is what ethics requires, and often we as a health worker, ethics is required of us, but we must not forget that we are going to people who have their culture, who have their "dogom miki" (lit. born found custom). So we must not disturb them in their culture. You have to be very, very careful. You have to be very delicate. I think that no matter what is in the culture, we can adapt. We're in an African society, eh? There will always be an imbalance [between man and woman]. There is nothing you can do, you have to adapt. But from my experience here, when you talk to men and they understand better, they easily accept. Usually when they are held up, it's because they do not understand. But as soon as they are given explanations, they easily adhere.

—Health provider, Fada

I think if everyone understands their role, they should be fine. Here in Africa, someone will stand up and say "we have come to raise awareness, here I have to do it like this" while the man wants something else. If the woman wants to take the advice and use her power, we men do not like it.

—District manager, Kaya

To address sensitive issues like contraception in culturally conservative societies, it is important to first gain the support of key influencers like community leaders. One study respondent highlighted that organizing advocacy sessions for local leaders is necessary to garner their support for family planning and a CFI approach.

It's like anything we do in our health area. We must first make pleas with local leaders. If they agree...we go to the traditional leaders [to see] if they agree, because they decide. It starts with them first. We hold general meetings with the people of the village, the advisors, and the Village Development Council, and we explain to them; if we have their support, there are no problems.

—District manager, Kaya

VI. DISCUSSION

The beliefs and perceptions of the respondents captured in this study provide valuable insights into the dynamics of FTP couples in Burkina Faso, particularly with regard to their communication and decision-making about health and family planning, and the possibilities of implementing CFIs to improve their sexual and reproductive health.

Couple Dynamics

Defining the “Couple”

E2A’s implementation experience working with FTPs in Burkina Faso has found that the majority of FTPs are in marriage relationships. Given this context, the study focused on couples comprising a husband and wife, while also recognizing that in Burkinabe societies some husbands have multiple wives. In addition, marriages described as “forced” persist, consisting primarily of arranged marriages. Refusing a forced or arranged marriage puts a person at risk of exclusion or lack of support in the event of problems in the couple. Many of the young FTMs in this study are in these types of unions, which are a form of GBV.

According to study findings, these types of marriages seem to be on the decline and the way in which young people enter unions is changing. Now, they are more commonly marrying for reasons of love or choice. Even so, the weight of the elder family members’ power continues to bear down on the choice of marital alliances, dictating that marriage is not only for the spouses, but also for the family clan. Given this, among both the FTMs and husbands in this study, caste remains an important criterion for an approved marriage, and the presence of children to continue their kinship lineage, gives marriage legitimacy. The definition of the couple, then, is focused on fertility and reproduction, and the capacity to propagate the clan. This makes marriage not just a two-person endeavor but one that has implications for the broader family.

Many of the FTP polygamous FTP relationships in this study were arranged, in keeping with cultural traditions—young women were promised to men by their parents and did not have the option to refuse the marriage. FTPs in monogamous relationships, at least at the time of the study, were typically of similar ages and from a younger generation. These were more likely to have entered the marriage for reasons of love and by choice. Even in these free-choice relationships, however, it was clear that the young FTPs were not able to move forward with their marriage decisions without the approval of their parents.

Couple's Communication

The accounts collected from FTPs in this study suggest that marriage type shapes, in part, a predisposition of husbands and wives to communicate and make decisions about health and family planning. The data indicate that in forced or arranged marriages, where the age difference between the spouses is sometimes substantial, the relationship is characterized by GBV and not conducive to intimate communication, particularly in a context where sexuality remains a taboo subject. While conflict is inherent in any relationship, findings suggest that it tends to be more prevalent among polygamous couples and in forced marriages. Some of the young women in polygamous relationships referred to tensions with co-wives. Moreover, the mere presence of co-wives under the same roof limits a couple's ability to communicate freely and privately about intimate matters between just the two spouses.

Monogamous FTP couples and those whose marriage resulted from romantic encounters were more likely to communicate about sex, health and family planning in general, although they too faced obstacles given the sensitive nature of these topics. FTMs typically live in multigenerational households that include their mothers- and fathers-in-law, as well as their husband's brothers (and their respective wives and their children). These living arrangements (as with the presence of co-wives for polygamous FTPs) makes finding private time and space to communicate extremely challenging. In addition, as young FTP couples entered marriage early and often with the corresponding social and economic vulnerability associated with early marriage, they are more heavily dependent on their parents. In these situations, conflicts within couples are common, thus negatively affecting the harmony in a relationship and their ability or desire to communicate.

In general, according to study respondents, couple communication on health issues occurs, with topics related to fertility and birth spacing discussed only in intimate, private spaces. Sexuality, however, remains a taboo subject which cannot be discussed in public. Although a discussion on preparing for the birth of a child can be initiated, there is no question of discussing the number of children a couple would like to have, because this remains a divine will. Contraceptive use itself was often referred to as a family secret that must not be discussed in public.

Influence of Gender Norms on Communication and Decision-Making

The communication behaviors of couples are strongly influenced by not only the modalities and forms of marriage, but also social norms related to femininity and masculinity that are deployed in marital relationships. The figure of the "good wife" and the roles assigned to her, coupled with the husband's presumed role as primary holder of power and decision-making authority, appeared to shape the communication experiences of many young women in the study. These norms impose on young women a model of conduct based on submission and silence. Furthermore, study findings reveal that wives are treated as outsiders in their husbands' families and are not invited to participate in discussions about the

family's issues. This subordinate role and denial of full participation in the family delegitimizes her opinions and impedes her ability to have a say in family affairs, without risking being called a "bad woman".

The gendered division of household tasks evident in the study communities acts as a major obstacle to couple's communication. Women have full and busy workdays while men often travel and work far from their communities. Although roles assigned to women and men have generally remained static, following previous generations' legacies and customs, there seems to be an emerging reconfiguration of men's roles that reflects more complementarity and sharing of household responsibilities among young couples.

Another way in which gender norms influence the dynamics of a couple is the clear double standard in how men and women's behaviors related to fidelity to their spouse is viewed. Male infidelity is an acceptable norm, while women's infidelity is condemned. Study findings suggest that conflicts between spouses are common as a result of suspicions about a wife's infidelity. Discussion of contraceptive use, (widely believed to promote sexual freedom in women) fuels those suspicions, making it difficult for women to broach the topic with their husband.

Contraceptive Use and Seeking Health Care

The gender norms that perpetuate unequal roles and expectations of women's ability to communicate and make decisions in the couple play a critical part in the use of family planning and other health services. Study findings suggest ambivalence about contraception—sometimes FP was perceived as beneficial for the entire family, while at other times it was understood as a risk factor for negative female behaviors (like infidelity) as well as female pathologies, including infertility.

The experience of FTMs in the study who were using contraception suggests they experienced a form of emancipation from their husband and an increased ability to take control of their own bodies. Many of the women began using contraception without their husbands' knowledge, developing strategies for covert use at the risk of suffering sanctions that range from the forced withdrawal of "long-acting" contraceptives, to marital conflict, to the potential for social stigma and shaming. Some of the factors that seemed to support those women who did communicate with and involve their husband about the decision to use FP is a sense of harmony in the relationship and a willingness to negotiate with their husbands despite the risks. However, a complex interweaving of the forms of marriage, local customs, prevailing social and gender inequalities and prescribed roles for women and men in society presented a formidable barrier that many FTMs in this study were not able to overcome.

Given that the social constructs of marriage and the couple are rooted in procreation in this context, an inability to bear children is considered a misfortune and is often a source of marital conflict. This socially engrained definition of marriage bolsters a couple's desire to have children, weighing heavily on husbands and wives and influencing their attitudes and decisions about contraceptive use.

The decision of FTMs to use a contraceptive method was primarily grounded in the belief that contraception benefits not just the woman, but also her child and family. This reasoning and focus on the overall health and wellbeing of the family allowed some husbands to accept the risk of doing something considered “secret” or “shameful.” In addition, the quality of the couple relationship appears to be a real catalyst in the use of FP and SRH services. Findings suggest that conflict or the lack of harmony determines the quality of the marriage and the couple’s ability to communicate and make joint decisions.

In general, men showed more willingness to be engaged in childbirth and curative care for their children, but remained steadfast against the idea of accompanying their wives to promotional or preventive services, such as ANC and FP, which were regarded as being for women only.

The role and involvement of mothers-in-law with regard to a couple’s dynamics and their use of health services appear to be mixed. On the one hand, from the perspective of the MILs themselves, their engagement in the couple’s life may be necessary due to their role as mediator of the couple’s conflicts to restore peaceful relations. In addition, MILs note that it is their responsibility to accompany young women to health services related to childbirth and the grandchild’s health needs. On the other hand, it appears uncommon for MILs to encourage contraceptive use except in cases where MILs were engaged in the day-to-day care of their grandchildren, in the event of closely spaced births.

Couple-Focused Interventions

In addition to exploring the dynamics of couple relationships, the study team also spoke with health care providers at the community and facility levels, national and district health officials, and FTPs to begin to assess the potential for implementing couple-focused interventions and to determine how key themes that emerged around couple dynamics can inform the design and structure of CFIs.

Awareness and Acceptability of CFIs

Study respondents were not familiar with the term and concept of couple-focused interventions. However, several hypothesized that interventions would involve only the husband and wife, and based on this understanding, seemed to recognize the potential benefits of CFIs. The benefits identified by participants focused primarily on providing transparent information about FP to both spouses, asserting that this would help to avert misunderstandings about methods and reasons for use.

At the institutional level, some health providers and district managers were familiar with a CFI approach applied through couples counseling in the field of HIV, and agreed that a similar approach would be beneficial for FP, noting the current difficulties in engaging men in health services.

Young FTMs and their husbands affirmed a willingness to participate in CFIs, with FTMs citing potential benefits such as increased knowledge about FP for both spouses. However, on the subject of going to health services together, study respondents reported that husbands generally do not want to go with their

wives to ANC or FP services due to prevailing social norms that make it highly unusual for men to go to promotional health services geared towards women.

Male Accompaniment in Health Services

As mentioned above, husbands appeared to be strongly resistant of accompanying their wives to preventive health services, such as ANC or FP. This perception was evident among institutional health actors and echoed by the FTMs and their husbands.

However, some husbands in the study suggested that they are willing to be involved in health care-seeking when services are related to curative or emergency care. This willingness seems even more prevalent when the child is sick, which is consistent with the centrality of children in marriage relationships.

Several FTMs highlighted the importance of husbands accompanying wives to health services. One advantage was explained as husbands receiving directly from health providers the same information about birth spacing and FP as the wives. They noted that this leads to both partners gaining a better understanding of these health issues and makes it more difficult for the husband to dispute the information since it came directly from a health provider rather than his wife.

Proposed CFI Strategies

Study respondents proposed several ideas and strategies for implementing CFIs and facilitating male involvement in those interventions. First, health providers indicated a need for a reorganization of health services to give men a place in SRH and FP service delivery. They mentioned making adjustments to infrastructure or scheduling that would better protect couples' privacy while accessing services. Some respondents also highlighted the need to reconfigure the health workforce—either in numbers or gender balance—and ensure that they have the technical competencies to deliver couple-focused interventions. In addition, from the perspective of a district health official, CFIs can only be implemented at the institutional level when the government is involved and invested in the approach.

At the community level, study respondents underscored the importance of building on prior experiences of working with community health workers to develop or strengthen a community-based service platform for CFIs. They mentioned enhancing the role of community actors and strengthening their communication skills so they can better reach men and couples with targeted FP counseling and services through home visits or small group discussions. One health provider also noted the importance of ensuring compliance with medical ethics in community-based care, including the preservation of confidentiality.

Additionally, many health providers in the study reflected on the importance of local and mass information, communication, mobilization and advocacy campaigns to promote social and behavior change among couples as well as influencers of FTMS at all levels of the socioecological model for FTP programming—from family members, peers and friends, to religious and traditional leaders. Although there seemed to be

a general assumption among some study respondents that norms rooted in customs or culture cannot be changed and must be respected, global evidence suggests that interventions can be designed to transform those norms to be more supportive of gender equality.²³

Findings suggest that one programmatic implication of the broad definition of the couple is that CFIs should be focused not only on the couple, but on the family. When discussing CFIs, a health provider in Fada brought up the central position that children occupy in the marriage. This, and the correlating strong joint interest of FTMs and their husbands in their children's health (discussed above, point to a potential need to include broader themes of parenting and child health in order to attract and sustain the involvement of husbands in CFIs.

An important issue that did not surface during the study interviews about CFIs was women's autonomy over their bodies and reproductive intentions. Study respondents considered CFIs to be beneficial for the family's health and assumed husbands needed to be involved because they are the primary decision makers. However, it is important to note that the focus of CFIs should instead be on joint decisions and joint actions, and ultimately recognize and affirm women's control over their own lives and bodies.

²³ E. Ruane-McAteer, K. Gillespie, A. Amin, et al., "Gender-transformative programming with men and boys to improve sexual and reproductive health and rights: A systematic review of intervention studies" *BMJ Global Health* 2020;5:e002997.

VII. PROGRAM CONSIDERATIONS

Findings that emerged from this study suggest several potential areas for programming as organizations consider implementing a couples-focused approach to work with FTPs in Burkina Faso. The program considerations listed below are informed by the qualitative data collected and the specific cultural context of the eastern region of Burkina Faso. They also are aligned with several key points of intervention described in E2A's recently developed theory of change for CFIs²⁴ which centers on the couple but also highlights the importance of family, social networks, institutional environments, and the cultural context in which couples live in order to improve family planning and reproductive health outcomes.

- **Create private, safe spaces for couples to discuss together healthy timing and spacing of pregnancy and family planning.** Both FTMs and their husbands in the study noted the challenges they face in finding time and space to communicate privately about intimate issues, due to FTMs' heavy workloads, husbands' travel or displacement, and households full of family members. In addition, study findings suggest that bringing both spouses together for interventions would increase the transparency and accuracy of the information couples receive. These opportunities could be used to address myths about contraception, help couples avoid potential misunderstandings about reasons for FP use, and link contraceptive use with the couple's desire to have and support a healthy family.
- **Test interventions that aim to improve the quality of the couple's relationship, to facilitate the couple's adoption of family planning and reproductive health behaviors.** According to study findings, FTP couples that lack harmony in their relationship due to conflicts in the family, unequal gendered power dynamics, or lack of mutual trust or respect are less likely to communicate and share decision-making about health and family planning. As reflected in E2A's theory of change for CFIs, there is some evidence that the quality of relationships is positively correlated with the adoption of healthy behaviors.²⁵ Interventions that emphasize the couple relationship as the target of change may work to build communication and negotiation skills, facilitate couple discussions about gender norms and relationship fidelity, and foster "couple connectedness," or the mutual bond between partners.

²⁴ Ramirez-Ferrero, Eric, Connie Lee, Erica Mills, and Ginette Hounkanrin. *Couple-Focused Interventions: A Theory of Change*. (Washington, DC: Evidence to Action Project, March 2021).

²⁵ M. A. Lewis, C. M. McBride, K. I. Pollak, et al., "Understanding health behavior change among couples: An interdependence and communal coping approach" *Social Science & Medicine*. 2006; 62: 1369–1380.

- **Address social and gender norms that lead to unhealthy practices and behaviors of married spouses.** Study findings confirm that the imbalance of power between the husband and wife in rural Burkina Faso, and the inequitable expectations that arise from notions of a “good wife” and a “good husband,” greatly inhibit communication and shared decision-making about issues regarding the health of FTPs and their families. These social and gender norms need to be addressed not only through interventions targeting the couple’s individual beliefs and attitudes, but also those of key influencers such as co-wives, in-laws, friends, peers, traditional and faith leaders, educators, and policy makers. Efforts should focus on transforming the normative environment surrounding FTPs to one that embraces more gender-equitable identities for men and women and the joint actions needed from FTP couples for improved health and relationships, while condemning GBV and respecting women’s autonomy.
- **Advocate for and support health system adaptations needed to better accommodate CFIs and increase male engagement.** Despite a general willingness to participate in CFIs among husbands in the study, most were adamant that men will not accompany their wives for family planning or other promotional health services due to the perception that these services are for women and it is unusual for men to attend. Health system adaptations that enhance training for providers to deliver couple-focused counseling and services, integrate FP into other health services more frequented by men, offer men services for their own health needs, and restructure hours and sites to create more privacy for men and couples may help to increase husbands’ participation in family planning services. In order to ensure these types of adaptations are institutionalized, national policies and guidelines should recognize and include men as family planning users, while district action plans should incorporate the specific budgets and activities needed to operationalize the adaptations.
- **Integrate FP into other health services that are more likely to be frequented by men and couples.** Based on study findings showing that men are more amenable to seeking care when it pertains to the health of their children, FP interventions that target both husbands and wives should be integrated into other health services such as child health and immunization. These types of FP integration have been implemented to varying degrees in other

countries,^{26,27,28,29} but using a CFI-approach to also reach husbands in these settings could potentially increase acceptability and uptake of FP among young FTP couples.

- **Provide targeted FP outreach, counseling and services for men and couples through a trained and supported cadre of community health workers.** In addition to adaptation and integration efforts to better reach and accommodate men and couples at the facility level, CFIs should aim to bring FP information and services tailored to men and couples to their communities. Group discussions and household visits conducted by CHWs are a ready and familiar platform in Burkina Faso on which these CFIs could be implemented, but additional technical and financial support may be needed to strengthen the capacity of CHWs to communicate and counsel effectively considering the couple as the unit of intervention.
- **Ensure protection of FTMs who may be experiencing violence perpetrated by their husband or other family members.** Since 2016, Burkina Faso has fallen into insecurity, especially in the eastern and northern regions, which include Fada and Kaya districts where this study was conducted. Some of the young FTMs interviewed were in situations of displacement, and it was during this period that they had entered into marriage. In addition, some FTMs revealed they were forced into marriage and appeared to experience trauma resulting from their situations. When there is widespread prevalence of the many potential forms of GBV and when FTMs are experiencing additional vulnerabilities due to displacement and forced marriage, CFIs would not be an appropriate approach to use. In these situations, it is imperative that efforts are in place to screen for and respond to violence experienced by young FTMs through protection and mitigation strategies—including legal aid, material assistance, health care, psychosocial support, and livelihood support—to prevent further violence.

²⁶ Family Health International (FHI). Integration of Family Planning and Immunization Services: Global Summary of Current Programmatic Experiences and Research Projects. Last updated November 2010. Accessed March 1, 2021.

<https://www.fhi360.org/sites/default/files/media/documents/family-planning-immunization-integration-global-summary.pdf>

²⁷ C. M. Cooper, J. Wille, S. Shire, et al., “Integrated family planning and immunization service delivery at health facility and community sites in Dowa and Ntchisi districts of Malawi: A mixed methods process evaluation” *Int J Environ Res Public Health*. 2020;17(12):4530. Published 2020 Jun 24. doi:10.3390/ijerph17124530.

²⁸ C. M. Cooper, A. Ogutu, E. Matiri, et al., “Maximizing opportunities: Family planning and maternal, infant, and young child nutrition integration in Bondo sub-county, Kenya” *Matern Child Health J*. 2017;21(10):1880-1889. doi:10.1007/s10995-017-2341-9.

²⁹ High-Impact Practices in Family Planning (HIP). Family Planning and Immunization Integration: Reaching postpartum women with family planning services. Washington, DC: USAID; 2013 Jul.

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