



PASSAGES PROJECT

Exploring social norms around reproductive health affecting unmarried adolescent girls in Burundi



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Cover photo: Diane Mpinganzima, adolescent and young women focus group participants at CDS Jabe, Bujumbura Mairie

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LIST OF ACRONYMS

AGYW	Adolescent Girls and Young Women ¹
ASC	Agent de Santé Communautaire
CERPED	Centre d'Etudes et de Recherche en Population et Développement
DHS	Demographic and Health Survey
FGD	Focus Group Discussion
FP	Family Planning
GBV	Gender-Based Violence
HIV	Human Immunodeficiency Virus
IRH	Institute for Reproductive Health at Georgetown University
ISTEEBU	Institut de Statistiques et d'études économiques du Burundi
LMIC	Low and Middle Income countries
MFF	Masculinité, Famille et Foi
MHM	Menstrual Hygiene Management
MSPLS	Ministère de la Santé Publique et de la Lutte contre le SIDA
NGO	Non-governmental Organization
PNSR	Programme National de Santé de la Reproduction
RH	Reproductive Health
SBCC	Social Behavior Change Communication
TPS	Technicien de Promotion de la Santé
SNET	Social Norms Exploration Tool
USAID	United States Agency for International Development

¹ We refer to the participants in this study as "adolescent girls and young women" to stay true to the terminology used in English for this category of girls aged 15 to 19. In Burundian society, however, unmarried women between the ages of 18 and 19 are still considered girls while those who are married are considered young women.

GLOSSARY OF SOCIAL NORMS TERMS

Descriptive norm: what was considered a typical or common behavior

Injunctive norm: what was considered an approved or expected behavior

Key influence group: people whose opinion or behavior influence a norm in terms of either enforcing it or supporting AGYW to go against it.

- **Enforcer:** influencer who enforced a norm
- **Social supporter:** influencer who supports AGYW or helps them overcome a norm

Outcome expectancy: social consequences that result from following or not following a norm

- **Negative sanction:** negative social consequences (e.g. punishments) of following or going against a norm
- **Positive sanction:** positive social consequences (e.g. rewards) of following or going against a norm

EXECUTIVE SUMMARY

This is the first study to document social norms that impact reproductive health behaviors among unmarried adolescent girls and young women² in Burundi. In addition to the important documentation that this study provides, we reflect on several key learnings that will inform future research and programs in this area and present five ideas for interventions to address our study findings.

In this study, we conducted 12 focus group discussions with unmarried adolescent girls and young women and 18 focus group discussions with other influential community members in four provinces of Burundi (Bujumbura Mairie, Bururi, Gitega, Muyinga). The focus group discussions focused on four domains of inquiry: 1) menstruation and menstrual hygiene management, 2) sexual risk behaviors, 3) sexual violence, and 4) fertility and voluntary family planning use. In each domain, we asked participants about what behaviors are typical among adolescent girls and young women in their communities, which of these behaviors are socially approved and disapproved of, and what types of people or groups influence these behaviors. In each province we conducted focus group discussions with adolescent girls and young women first. We then recruited the groups of people they reported as influencers for focus group discussions focused on the same domains of inquiry. We conducted focus group discussions with mothers of adolescent girls and young women, health providers, *agents de santé communautaire* (community health workers), teachers, peer educators/student health club members and local leaders (i.e. local administrators, religious leaders, and members of a child protection committee).

Using our analytic criteria, eight social norms emerged as having the greatest influence on adolescent girls and young women's reproductive health behaviors and outcomes:

1. Sexuality and reproductive health are not discussed openly in households or the community and it is not considered socially acceptable to do so;
2. It is not socially acceptable to show any evidence of menstruation;
3. Girls are expected to behave differently after they begin menstruating;
4. Sexual activity among unmarried adolescent girls and young women appears common but not socially approved of;
5. Having sex in exchange for gifts or money appears common;
6. Instances of coerced sex appear common and girls who experience sexual violence are typically socially shamed;
7. It is becoming less socially acceptable to have more children than one can care for; and
8. Adolescent girls and young women do not typically use contraception and it is not considered appropriate for them to use contraception.

Focus group participants discussed most of these social norms as cutting across several of the domains of inquiry, and all of them as being influenced by multiple groups of people and as having both social and health consequences for adolescent girls and young women.

² We refer to the participants in this study as "adolescent girls and young women" to stay true to the terminology used in English for this category of girls aged 15 to 19. In Burundian society, however, unmarried women between the ages of 18 and 19 are still considered girls while those who are married are considered young women.

In terms of key influencers of these social norms, parents, health providers (including *agents de santé communautaire*), peers and friends, sexual partners, teachers, religious leaders, neighbors and other family members were the groups most commonly mentioned (by adolescent girls and young women and influence group participants). The influence that these groups exerted on girls ranged from enforcing norms and punishing adolescent girls and young women who did not comply to providing support to adolescent girls and young women to overcome harmful norms. We also noted that some influence groups were named substantially more frequently than others while some groups albeit named infrequently were discussed as having substantial influence.

Based on our findings and our knowledge of current social norms research and interventions for adolescent girls and young women and reproductive health, we elaborate several key learnings and ideas for future interventions. Specifically, we reflect on the following three key learnings for future research and programs on social norms, adolescent girls and young women, and reproductive health:

1. The existence of a large variety of influence groups who play multiple roles in both upholding norms in the community and in the lives of the target population is an important consideration not only in the interpretation of our findings but also for all future social norms research and interventions.
2. By using a rigorous multi-step approach to identifying and engaging key influencer groups, we were able to engage and reflect a wide array of influence groups with differing perspectives on the issues.
3. Despite significant discussion and recognition of norms for adolescent girls and young women's reproductive health existing in the larger social context, adolescent girls and young women and key influencers in this study placed significant onus on individual adolescent girls and young women to comply with the norms and held them individually responsible for not complying.

Finally, we suggest that to improve the reproductive health and well-being of adolescent girls and young women in Burundi it will be necessary to implement interventions that extend beyond individual-level behavior change and beyond providing education and care and explore ways that programs can shift norms at the community level. We therefore advance the following five specific ideas for potential entry points and accompanying strategies for future interventions to shift the norms and engage the key influence groups identified in this study:

1. Create positive new norms for more open discussion of sexuality, menstruation and reproductive health with family members;
2. Create safe spaces & improved access for adolescent girls and young women to become informed about sexuality and reproductive health;
3. Confront gender and power imbalances contributing to sexual risk;
4. Engage religious leaders as champions for family planning; and
5. Explore underlying drivers of health workers' bias.

The findings and ideas laid out in this report contribute to the capacity of the Burundian government and NGOs to rise to the demographic challenges posed by its large youth population and high fertility rates and simultaneously to the evidence base needed to strengthen normative environments that support the reproductive health and well-being of adolescents globally.

INTRODUCTION

Background

Burundi is a densely populated country of over 12 million people, 65% of whom are under the age of 25 [1]. Given the large percent of the population, currently or still to be, in their reproductive years and an estimated fertility rate of 5.5 children per woman in 2017 [2], Burundi faces severe demographic pressure. The government of Burundi is committed to enabling women, couples, and families to have the number of children they desire and decreasing unmet need for family planning (FP). Improving access to and use of FP is featured in the 2019-2023 National Sexual Reproductive Health Strategy and Vision Burundi 2025 [3].

Progress on key FP and other reproductive health (RH) indicators for Burundian women, however, has been slow; especially for adolescent girls and young women (AGYW). Poor comprehensive knowledge around RH, low uptake of FP methods, and high fertility rates are characteristic of this population. For instance, in nationwide surveys just over half (57%) of AGYW 15 to 24 years of age in Burundi reported that a woman cannot become pregnant the first time she has sexual intercourse [4]. According to the 2016/2017 Demographic and Health Survey (DHS), nearly half (45.2%) of AGYW respondents ages 15 to 24 years report that their previous pregnancy was unplanned, and fertility rates among adolescent girls 15 to 19 years and young women 20 to 24 years, are among the highest in the world at 58/1,000 and 218/1,000, respectively [2].

Burundi is also a country characterized by a history of violent conflicts; the most recent being the civil war that endured from 1993 – 2005. Much has been written about the ubiquity of sexual violence during wars as well as continued high rates of gender-based violence (GBV) in post conflict settings. Burundi has a National Protocol on the Treatment of Sexual Violence, which was developed in 2005 with the support of UNICEF and UNFPA and provides an important framework for coordination of the medical response to sexual violence [5]. The impact of sexual violence ranges from short-term trauma to longer term issues, including unintended pregnancies. A survey conducted in 2018 among a representative sample of 744 AGYW aged 15–24 in eight provinces in Burundi found that 26.1 % reported having ever been physically forced to have sexual intercourse and that these AGYW were 2.3 times more likely to report that their last pregnancy was unplanned [6]. Reliable statistics on sexual violence in Burundi; however, remain difficult to obtain and this is thought to be due in large part to the stigmatization of victims [7]. Stigmatization is one form of social sanction to ensure compliance with social norms—the unspoken social rules that govern behavior [8].

Social norms are particularly salient among young people given that they have less power in societies and because relationships with peers begin to intensify during the period of adolescence. Moreover, adolescence is a period when gender roles are being solidified, which has been shown to impact RH behaviors in particular [9-13]. For instance, studies from a range of countries have found that the age of sexual initiation of one's adolescent peers is a strong predictor of one's own age of sexual initiation. Similar relationships have been shown between peers' contraceptive use and one's own use [14]. Likewise, research has shown a relationship between an individual's experience of sexual violence and that of their peers [15]. To date, much of what is known about how social norms operate among adolescents is from high income countries with little data from low- and middle-income countries (LMICs). However, research on what works to change social norms to improve adolescent

RH is emerging from sub-Saharan Africa. For instance, research in sub-Saharan Africa has highlighted the role of social norms in adolescent condom use [16, 17], the perpetration of sexual violence [18], transactional sex [19], and multiple partnerships and early sexual initiation [20].

In Burundi, social norms are not well-documented but are likely to have a large influence on AGYW's ability to access RH information and care, their RH behaviors, and ultimately their health outcomes. To fill this evidence gap, Burundi's Ministère de la Santé Publique et la Lutte contre le SIDA (MSPLS)'s Programme National de Santé de la Reproduction (PNSR) worked in partnership with FHI 360 to develop an exploratory study about these issues. The study was funded under the USAID Passages project, a six-year cooperative agreement led by the Georgetown University Institute for Reproductive Health (IRH). Passages aims to address the root of chronic challenges in FP and RH — such as gender-based violence and unintended pregnancy — by transforming social norms. Passages also seeks to build the evidence base and contribute to the capacity of the global community to strengthen normative environments that support RH and well-being, especially among young people at life course transition points, including very young adolescents, newly married youth, and first-time parents.

As part of the Passages project, the objectives of this study were: 1) to explore social norms related to AGYW's RH knowledge and behaviors in Burundi; and 2) to identify relevant individuals and groups who influence and enforce these social norms. In this study, we use the term reproductive health (RH) as an umbrella term that incorporates all of the physical and developmental health issues that AGYW confront during adolescence that have immediate and long-term impacts on their reproductive system and ultimately their health and well-being. We explored social norms around four specific domains of inquiry related to RH: 1) menstruation and menstrual hygiene management (MHM), 2) sexual risk behaviors, 3) sexual violence, and 4) fertility and voluntary use of family planning. This study was designed to expand the knowledge base around social norms for AGYW RH in Burundi and inform future norms-shifting interventions designed to improve RH knowledge and behaviors among AGYW in Burundi.

METHODS

Under the direction of Burundi's PNSR (see Appendix A for members of study team) and FHI 360, this exploratory descriptive study was conducted using focus group discussions with unmarried AGYW (ages 15-19) and individuals they identified as influencing their RH behaviors. The content of the FGD guides was developed using global and local evidence on how social norms influence RH behavior. The MSPLS appointed a technical and steering committee (see Appendix B for list of technical and steering committee members) to provide input and oversight to the study. The technical committee reviewed and provided significant input on the study protocol, informed consent forms, data collection guides and study report and the steering committee conducted supervision visits to ensure that data collection was in adherence with the protocol. The protocol was reviewed and approved by the Comité National d'Ethique du Burundi and FHI 360's Protection of Human Subjects Committee. The protocol was also submitted and received a statistical visa from l'Institut de Statistique et d'études économiques du Burundi (ISTEEBU). Data collection was conducted by the Centre d'Etudes et de Recherche en Population et Développement (CERPED).

Site Selection

To obtain geographic and urban/rural diversity, the study was conducted in four provinces in Burundi: Bujumbura Mairie, Gitega, Bururi and Muyinga.



Figure 1: Map of Burundi showing four provinces in which study was conducted

Table 1: Characteristics of the study provinces

Province	% of residents who live in urban or rural areas [22]	# of health facilities	Median age at first intercourse [2]	Median age of first union [2]	TFR [2]	% of adolescents aged 15-19 who have begun childbearing [2]
Bujumbura Mairie	100% urban	Bujumbura City municipality includes 179 health facilities, including 25 public, 10 faith-based, 14 associations and 130 private	20.5 years	24.4 years	3.7 children	11.8%
Bururi	97% rural	60 health facilities including 27 public, 13 faith-based, an associative and 9 private	20.8 years	21.9 years	4.4 children	4.1%
Gitega	94% rural	94 health facilities throughout Gitega including 46 public, 24 faith-based, 5 associative and 19 private	20.8 years	21.8 years	5.5 children	4.3%
Muyinga	98% rural	74 health facilities including 43 public, 10 faith-based, 2 associative and 19 private	18.3 years	19 years	6.6 children	13.3%

Sampling, eligibility criteria and recruitment strategy

Sample size

Evidence indicates that 80% saturation of study themes can be reached within 3 FGDs and 90% within 5 FGDs [21]. Therefore, we conducted 3 discussion groups with AGYW and either 4 or 5 FGDs with the influence groups in each province. For each FGD, we set an upper limit of 10 participants and a minimum of 6 participants.

Eligibility Criteria

Adolescent Girls and Young Women

In each study community, AGYW were considered eligible for participation if they met the following study criteria:

- Resident of that community for 2 or more years;
- Single (unmarried and not living together with a partner);
- Between 15 and 19 years of age, inclusive;
- For 15-17 year olds, willing to provide assent and parental/guardian consent; and
- For 18-19 year olds, willing to provide informed consent.

Influence Groups

We were interested in talking not only to AGYW but also to individuals in the community who influence the AGYW's behaviors and the social norms that enforce and reinforce these behaviors. Standard social norms terminology uses the term "reference group" to refer to the individuals who either engage in the behavior that is considered the norm or who enforce compliance with the norm in a specified social group. For the purposes of this study, we chose instead to use the term "influence group" as we specifically asked about who influenced AGYW's behavior and compliance with social norms.

In order to select which influence groups to enroll in our study, at the end of each AGYW FGD, we asked AGYW participants to close their eyes and raise their hands to vote for the influence group they felt was the most influential to AGYW's behavior in each domain. Facilitators read the full list of influence groups that were mentioned and each AGYW was allowed to vote anonymously for the top 3 most influential groups. The study team subsequently tallied the votes and simultaneously considered the feasibility of recruiting each group and whether that group's perspective had already been incorporated in the data collected. Influence group members in each study community, were considered eligible for participation if they met the following study criteria:

- Resident of that community for 2 or more years;
- Age 15 or over;
- For participants 15-17 years old, willing to provide assent and parental/guardian consent; and
- For participants 18 or older, willing to provide informed consent.

Recruitment Strategy

Provinces in Burundi are further divided into communes and collines, which are smaller administrative areas within communes. We were provided with a list of all collines in each of the four provinces. The list also indicated whether the colline was designated as a rural or urban location. To ensure an equal representation of urban and rural collines, we first stratified the lists by rural and urban. We then used a random number generator to randomly select collines from within the rural and urban strata. Once the collines were selected, the PNSR sent letters of introduction and requests for authorization from the appropriate Ministries and provincial level authorities. These documents allowed for study deployment in the field. The field supervisor or a representative designated by the technical committee then contacted the relevant health and administrative authorities to describe the study and provide the letters of authorization. At the same time, the field supervisor obtained the names and contact information of the community health officers known as *technicien de promotion de la santé* (TPS) and briefed them on the eligibility criteria for FGD participants. The TPS then collaborated with agents de santé communautaire (ASCs) and school officials in the study sites to identify and recruit in-school and out-of-school, older (18-19) and younger (15-17) AGYW meeting eligibility criteria. Specifically, recruiters went to schools and health centers to recruit a convenience sample of AGYW.

Once the types of influence groups (i.e., health providers, teachers, etc.) were identified from the FGDs with AGYW, influence group members were similarly recruited by the ASCs and TPSs serving that community. We asked ASCs and TPSs to recruit influence group members who lived in the same colline as the AGYW participants. Once we determined who the influence groups were in each

community, we worked with ASCs and TPSs to identify and approach individuals who met these criteria. ASCs and TPSs used a recruitment script to invite influence group members to a pre-determined location and time for the FGD.

Data Collection

Data Collection and Analysis

All data collection was conducted by qualified Burundians researchers and research assistants who received study-specific and research ethics training and obtained research ethics certification. Data were collected first in Bujumbura Mairie (December 8-14, 2019), then Gitega (December 16, 2019-January 7, 2020), then Bururi (January 6-14, 2020), and Muyinga (January 12-21, 2020).

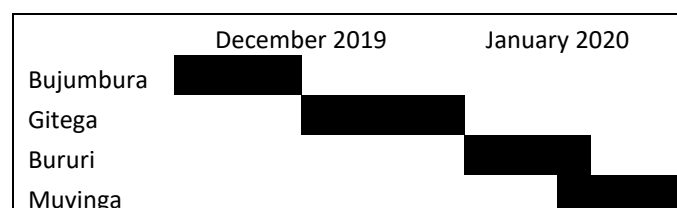


Figure 2. Timeline of data collection

Data Collection Forms and Discussion Guides

We developed two focus group discussion guides; one for AGYW and one for influence groups (see Appendix C). The two guides contained the same domains of inquiry and were structured to ensure consistency and thoroughness of topics covered but allow some flexibility to explore emergent topics. Both guides were translated in Kirundi and French and all FGDs were conducted in a combination of French and Kirundi and audio recorded with the permission of the participants. The central domains of inquiry focused on the four behavioral concerns for AGYW in Burundi chosen as the focus of this study: 1) menstruation and MHM), 2) sexual risk behaviors, 3) sexual violence, and 4) fertility and voluntary use of family planning. At the beginning of each FGD, we asked every participant to respond to a few demographic questions such as age, highest education level, and whether they had any children.

Within each domain of inquiry, we asked what was the common behavior or practice among AGYW in that community (see Table 2, column 2) as well as what was considered the socially acceptable/approved of behavior for AGYW. We also asked about what social consequences AGYW faced if they did not comply with what was the common and/or socially approved of behavior or practice and finally about who in the community influenced these behaviors and/or the related social norms.

In the menstruation domain, we began by asking about typical age of menstruation and then about practices that are considered core to MHM. In the sexual risk behaviors domain, we began by asking about age of sexual debut and generally how common sex was among unmarried AGYW and then segued into several different types of sexual activity that may put girls at risk for poor health outcomes. One of these behaviors was sex in exchange for gifts or money, hereafter referred to as transactional sex. There are multiple definitions of what constitutes sexual violence. For the

purposes of this study, we asked about the occurrence and acceptability of three behaviors that are commonly considered to be forms of sexual violence (see Table 2, column 2). Distinct from the other domains, the questions in the sexual violence domain were worded so as to get at behaviors in the community that would involve and affect AGYW rather than behaviors initiated by AGYW. In the fertility and family planning domain, we asked about contraceptive use as well as about typical and desired family size.

The FGDs also included a problem tree exercise selected and adapted from the Social Norms Exploration Tool (SNET) (see Appendix D for illustrative example of problem tree completed in our study)[22]. Developed with support from the Passages Project and members from the Bill & Melinda Gates Foundation-funded Learning Collaborative to Advance Normative Change, the SNET is designed to be a rapid assessment tool to gather information at the community level in order to quickly develop a preliminary understanding of the social norms operating in program communities. The SNET provides a menu of different participatory activities that can be used for exploring social norms. We chose developing problem trees as the activity that we felt would be most useful as a participatory way to get FGD participants to reflect broadly on the causes of AGYW RH issues. We also liked this activity as a way to illustrate how social norms are often just one root cause among several intersecting causal factors.

To decide which problem FGD participants would discuss, participants in the AGYW FGDs and the Bujumbura key influencer FGDs were asked to rank what they thought “constitue un problème majeur pour les jeunes” in their communities. When we moved to the next three provinces, in order to ensure that problems related to each of the domains of inquiry were discussed, the study team pre-selected a problem for the influence group participants to discuss. The selection of problems in these FGDs was based on which key influencers were voted by AGYW to be most significant to each domain. Once the problem to be discussed was selected or presented to the participants, they then completed a problem tree exercise to explore root causes of the selected problem.

Table 2: Focus Group Guides’ Behaviors and Topics discussed by Domains of Inquiry

Domain of Inquiry ^a	Specific Behaviors /Practices asked about	Additional Contextual Questions	Problem Tree Focus by Participant Type (# of FGDs)
Menstruation and MHM	<ul style="list-style-type: none"> What girls use to absorb blood Where girls obtain, dispose of, or clean the material How girls clean themselves during menstruation 	<ul style="list-style-type: none"> Age of onset of menstruation 	<ul style="list-style-type: none"> Adolescents n=2 Key Influencers n= 4
Sexual risk behaviors	<ul style="list-style-type: none"> Pre-marital sex Multiple partners Sex in exchange for gifts or money Sex after drinking alcohol 	<ul style="list-style-type: none"> Typical age girls start having sex 	<ul style="list-style-type: none"> Adolescents n=10^b Key Influencers n= 7
Sexual violence	<ul style="list-style-type: none"> Being beaten or hit by sexual partners 	<ul style="list-style-type: none"> Reporting of sexual violence 	<ul style="list-style-type: none"> Adolescents n=0 Key Influencers n= 3

	<ul style="list-style-type: none"> • Being pressured by partners or others to have sex • Being forced to have sex by partner or another person 	<ul style="list-style-type: none"> • Consequences for perpetrators of sexual violence 	
Fertility and voluntary use of family planning	<ul style="list-style-type: none"> • Contraceptive use, including condoms 	<ul style="list-style-type: none"> • Desired family size (AGYW) • Typical family size (influence groups) • Availability and accessibility of contraception for AGYW 	<ul style="list-style-type: none"> • Adolescents n=0 • Key Influencers n= 4

^a As with any qualitative inquiry, not all domains were discussed in every FGD. In particular, in this study some topics were not discussed by some key influencer FGDs as priority was given to having them focus on the topics about which they were most knowledgeable.

^b Nine adolescent FGDs selected unprotected sex and/or unintended pregnancy as the problem they would like to discuss. Although, sexual risk, sexual violence and family planning concerns were all noted as root causes for this behavior, all of these problem trees are classified here under the sexual risk behavior domain.

Analysis

Audio recordings of the FGDs were transcribed and translated verbatim into French transcripts. We created a codebook that consisted of structural codes from the interview guide as well as structural codes for the themes of interest to this study. For the purposes of this analysis, we sought evidence of social norms related to RH among AGYW as well as descriptions of the key influencers and consequences (i.e., both outcome expectancies and health outcomes) related to these norms. We defined the codes for these terms in the following way:

- Descriptive norm: what was considered a typical or common behavior
- Injunctive norm: what was considered an approved or expected behavior
- Key influence group: people whose opinion or behavior influence a norm in terms of either enforcing it or supporting AGYW to go against it
 - Enforcer: influencer who enforced a norm
 - Social supporter: influencer who supports AGYW or helps them overcome a norm
- Outcome expectancy: social consequences that result from following or not following a norm
 - Negative sanction: negative social consequences (e.g. punishments) of following or going against a norm;
 - Positive sanction: positive social consequences (e.g. rewards) of following or going against a norm.
- Health outcomes related to social norms.

We also used an analysis matrix with all the codes in the codebooks to summarize the data for each domain in each social norm category. Four coders coded transcripts using NVivo qualitative software (QSR International, Version 12.0) and filled out the matrices (using Microsoft Excel). To ensure consistency, each analyst's first transcript was coded and the matrix was filled out by another analyst and then consistency was assessed and discussed. This resulted in three in-depth consistency meetings. Additionally, the analysts frequently discussed coding questions and reviewed each other's

coding and matrices throughout the coding process to ensure consistent use of the codebook and matrix.

Data in the matrices and Nvivo coding reports for each domain were systematically reviewed and further reduced to separate and pull out descriptive and injunctive social norms, outcome expectancies and influence groups. We first looked for evidence of norms within domains of inquiry. We then looked across domains of inquiry to identify norms that were crosscutting across behaviors. We identified the most common descriptive and injunctive norms that appear to impact AGYW's RH, meaning those that were described in the majority of FGDs. We also included descriptions of norms that were less frequently discussed if participants presented them in a way that conveyed that they were or could be significant in that social context. This process led to identification of “key” norms which impacted RH for AGYW, which we describe in the Findings section. For each of the key norms identified, we describe the outcome expectancies (positive and negative sanctions) and the key influencer groups that were discussed as relevant to each social norm.

We followed the same process in analyzing the AGYW and key influence group transcripts. Differences between what adolescents and key influencer participants said and what was said in different provinces are noted in the Findings section where applicable. As discussions were semi-structured and open-ended, not every topic or theme emerged in every transcript. Therefore, as is common in qualitative research, exact numbers of participants or transcripts are not usually presented, rather general quantifying language such as “most” or “a few” was used. The unit of analysis was the FGD transcript, so if something was discussed in more than half of FGDs transcripts, we use “most” or “the majority” to describe this. When we make mention of the number of participants who discussed something, we also attempted to simultaneously qualify the approximate number of transcripts or provinces in which this discussion emerged.

In an effort to best represent what participants said in their own words, we provide verbatim text as much as possible throughout the Findings section. Specifically, text that is written in quotes are participants' words and opinions as expressed verbatim from the transcripts and were selected as the most illustrative example for each finding.

FINDINGS

Sample Characteristics

By design, all of the participants in the adolescent focus groups were unmarried girls and young women between the ages of 15 and 19 years (Table 3). In other demographic characteristics, there was some variation by province. This variation may reflect some extent of underlying provincial differences. However, given that this is a small sample, it is not necessarily representative at the provincial level and largely just reflects where we were able to recruit AGYW in that province.

Current enrollment in school varied greatly by province: in Bujumbura all girls were in school, most were in school in Gitega, fewer than half were in school in Muyinga and very few were in school in Bururi, where most had only completed primary school. There was variation in religion with similar numbers reporting they were Catholic and Protestant and fewer reporting that they were Muslim. Almost all lived with one or both parents. Very few had ever been in a health club. Fewer than half of

AGYW participants overall said they had ever had sex, with large variation by province: very few in Bujumbura and few in Gitega reported that they had had sex, whereas in Muyinga nearly half and in Bururi three-quarters reported having had sex. In Bururi, most adolescent participants had at least one child and in Gitega and Muyinga only a couple had children.

Table 3. Demographic characteristic of unmarried AGYW participants by province of participation

Province	Bujumbura Mairie n (%)	Bururi n (%)	Gitega n (%)	Muyinga n (%)	Total N (%)
No. FGDs	3	3	3	3	12
Total no. participants	22	24	22	23	91
Average age (range)	17 (15-18)	17 (15-18)	17 (15-19)	17 (15-18)	17 (15-19)
Currently in school	100%	17%	82%	48%	60%
Highest Education level completed:					
Primary:	0%	83%	0%	39%	32%
Secondary:	91%	17%	95%	61%	65%
Superior:	9%	0%	5%	0%	3%
Religion					
Catholic:	45%	25%	59%	52%	45%
Protestant:	32%	75%	36%	22%	42%
Muslim:	23%	0%	5%	26%	13%
Live with:					
Parents:	95%	88%	77%	87%	87%
Other family:	5%	8%	18%	13%	11%
Other (famille de son patron; seule):	0%	4%	5%	0%	2%
Ever been in a health club	23%	0	23%	22%	16%
Ever had sex	14%	75%	23%	48%	41%
Has child(ren)	0%	63%	9%	13%	22%
Avg. no. children (range)	NA	1 (1-4) (n=15)	1 (both had 1) (n=2)	1 (1-2) (n=3)	1 (1-4) (n=20)
^a The health clubs referred to here are generally school-based clubs that include male and female youth and focus on HIV and reproductive health.					

A large variety of key influencer groups participated in FGDs, including mothers, health providers, teachers, ASCs, local administrators, peer educators, health club students, members of a child protection committee, and religious leaders (Table 4). Note that religious leaders included members of Muslim and Christian faiths, who represented different functions within the faith community (i.e. not solely the priest, pastor or imam).

Table 4. Number and types of different influence groups interviewed by province

Province	Bujumbura Mairie (n)	Bururi (n)	Gitega (n)	Muyinga (n)	Total N
Mothers of girls ages 15-19	2	1			3
Health providers	1		1	1	3
ASCs		1		2	3
Peer educators/ Health Club students		1 Peer educators	1 Health club students		2

Teachers		1	1	1	3
Local Leaders	1 Local Administrators	1 Local Administrators	1 Members of a Child Protection Committee	1 Religious Leaders	4
Total	4	5	4	5	18

Across the 18 FGDs with key influencers, there were 129 total participants. The majority were female and had children (average 4 children per participant) (Table 5). Most had completed secondary education or higher and were married. In terms of religion, half were Catholic, 40% were Protestant and 11% were Muslim (in Bujumbura and Muyinga only).

Table 5. Key influencer characteristics

Province	Bujumbura Mairie	Bururi	Gitega	Muyinga	Total
No. of FGDs	4	5	4	5	18
Total no. participants	30	38	27	34	129
Average age (range)	42 (30-65)	40 (19-63)	40 (17-75)	40 (24-60)	40 (17-75)
Gender					
Female:	100%	74%	63%	59%	74%
Male:	0%	26%	37%	41%	26%
Highest education level completed					
Less than primary:	0%	10%	0%	3%	4%
Primary:	13%	29%	22%	29%	24%
Secondary:	83%	58%	48%	68%	64%
Superior:	3%	3%	30%	0%	8%
Marital status					
Single:	27%	24%	30%	3%	20%
Married or cohabiting:	73%	76%	63%	94%	77%
Widowed:	0%	0%	7%	0%	2%
Divorced:	0%	0%	0%	3%	1%
Religion					
Catholic:	40%	45%	70%	47%	50%
Protestant:	40%	55%	30%	29%	40%
Muslim:	20%	0%	0%	24%	11%
Has child(ren)	97%	76%	70%	97%	85%
Avg. no. children (range)	4 (1-9) (n=29)	4 (1-8) (n=29)	3 (1-16) (n=19)	4 (1-8) (n=33)	4 (1-16) (n=110)

Key social norms that impact AGYW's RH

In our analysis, we identified eight key social norms, described by adolescent and key influencer participants, which influence AGYW's RH and wellbeing. Notably, most of these social norms cut across multiple domains of inquiry. We describe the relevant individuals and groups who influence each social norm and use **bold** type to indicate who these were. We also describe the consequences (both outcome expectancies and health outcomes) that were discussed of these norms.

Table 6. Key social norms (and norm type) that impact AGYW's RH

Social norm #1: Sexuality and RH are not discussed openly in households or the community and it is not considered socially acceptable to do so (Descriptive and injunctive norms)
Social norm #2: It is not socially acceptable to show any evidence of menstruation (Injunctive norm)
Social norm #3: Girls are expected to behave differently after they begin menstruating (Injunctive norm)
Social norm #4: Sexual activity among unmarried AGYW appears but not socially approved of (Descriptive and injunctive norm)
Social norm #5: Having sex in exchange for gifts or money appears common (Descriptive norm)
Social norm #6: Instances of coerced sex appear common and girls who experience sexual violence are typically socially shamed (Descriptive and injunctive norms)
Social norm #7: It is becoming less socially acceptable to have more children than one can care for (Emerging descriptive and injunctive norms)
Social norm #8: AGYW do not typically use contraception and it is not considered appropriate for them to use contraception (Descriptive and injunctive norms)

Social Norm #1: Sexuality and RH are not discussed openly in households or in the community and it is not considered socially acceptable to do so (Descriptive and injunctive norms)

Descriptive norm

In all transcripts, including in the problem tree exercises across domains, adolescent and key influencer participants stated that in their communities and households anything related to sexuality and RH, including menstruation and MHM, use of contraceptives, and sexual risk behaviors including incidents of sexual violence are not typically discussed openly, especially between parents and girls. For example, a participant in an FGD with ASCs in Musinga said,

In general, in our Burundian culture, parents are ashamed to discuss with their children what concerns the genitals and you even see that menstruation includes these private parts on which the Burundians are ashamed to discuss.

Many adolescent and key influencer participants across provinces described that many girls are not given the biological information needed to understand that they can become pregnant. For example, they are not given information about the fertile period of the menstrual cycle (“*la période de fécondité*”) or knowledge on how to correctly use condoms (“*connaissance sur l’usage correct des préservatifs*”). Lack of communication between **parents** and girls about sexual intercourse and menstruation appeared to go both ways in that **parents** do not feel comfortable talking to girls about these issues while girls were often described as having shyness (“*timidité*”) or shame (“*honte*”) to discuss these issues with their parents. For example, in an FGD with teachers in Gitega, one participant explained,

They lack knowledge because they consider menstruation a taboo subject, because culture does not allow us to speak openly about menstruation, that is, there is a lack of information.

This lack of communication was also sometimes attributed to parental neglect or ignorance (“*négligence des parents*”, “*l’ignorance des parents*”) or parents being uneducated and not knowing how to practice good hygiene.

Injunctive norm and consequences

Across all FGDs the idea of openly talking about sexuality (“*la sexualité*”), RH or sexual violence was often described by participants as taboo (“*tabou*”) (e.g., “*Communication on sexuality is a taboo subject in Burundian culture*”-Teacher FGD, Bururi.) Across FGDs, parents³, especially mothers, were the influence group most discussed as enforcing this communication norm. For instance, many adolescent and key influencer participants across provinces described that it is not socially acceptable for **parents** to talk to their daughters about sex beyond telling them to abstain from sex. However, across domains of inquiry, several other different types of key influencers were mentioned as also enforcing this injunctive norm including neighbors, teachers, religious leaders, and local administrators. Some key influencers, however, went against this norm by providing information to AGYW, namely school-based health clubs, peer educators and health providers, including ASCs. Older sisters, aunts, and female friends were also discussed as sharing information with AGYW about these issues, however the information did not always appear to be accurate.

However, there was considerable discussion in most AGYW and key influencer FGDs about how compliance with this injunctive norm led in turn to several negative consequences for AGYW; including AGYW being ignorant (“*ignorantes*”) and unprepared for menstruation and sexual debut. It was often discussed in the FGDs that this lack of preparedness and understanding resulted in girls practicing poor MHM, having unprotected sex, experiencing unintended pregnancies and experiencing and not reporting sexual violence. For instance, a few adolescents and several key influencer participants across provinces described some girls as being so uninformed that they are surprised the first time they menstruate, sometimes believing they are injured. This is illustrated by a participant from an FGD with teachers in Musinga:

I can talk about the dialogue between parents and children regarding sexual and reproductive health, so this dialogue does not exist! Why? Because of social norms, parents think that by talking about this with their children, they will be saying bad things. That’s why menstruation comes as a surprise to 13- or 14-year-olds.

Lack of accurate communication about contraception was discussed in most FGDs as leading to many misconceptions about the health consequences of contraceptive use; such as that it can cause infertility and that a condom can get stuck inside a woman. This is illustrated by adolescents in a Bururi FGD:

Participant (P1): Often they do not have knowledge about the use of condoms, even those who give them training are afraid because they do not have sufficient knowledge.

P2: They are afraid that the condom might stay inside.

M: Does it happen?

P3: By the way, they don’t have the necessary training on condom use.

This lack of information was also discussed as contributing to AGYW having unprotected sex and experiencing unintended pregnancies.

³ Though participants spoke about “parents” generally, they were often specifically referring to mothers.

Social Norm #2: It is not socially acceptable to show any evidence of menstruation (Injunctive norm)

Injunctive norm and consequences

A common perception of normative expectations for menstruation, discussed by the majority of adolescents and key influencers across provinces, was that girls must know how to be clean and hide any evidence that they are menstruating. Across the majority of FGDs that discussed menstruation, evidence of menstruation (i.e., odor, stain, menstrual hygiene products) was discussed as something shameful and socially unacceptable. In terms of typical MHM practices, it was widely agreed upon that girls who have the means (e.g. those who live “*en ville*” or whose parents are officials) use Cotex⁴ (sanitary pads) whereas girls who lack the means use “*morceaux de tissu*” or “*morceaux de vêtements*” (usually a piece of cloth/“*pagne*”, often from their mother) which they wash, dry in the sun, and reuse. Many girls who use “*morceaux de tissu*” have trouble changing them at school and experience odor or stained uniforms and it emerged in adolescent and key influencer FGDs across provinces that girls would prefer to use Cotex if they could.

Several social consequences were mentioned as resulting from evidencing menstruation in any way, the majority of which affected girls’ schooling. For instance, adolescents in an FGD in Muyinga describe how having menstrual odor can lead to stigmatization, school absenteeism and even dropping out of school:

Moderator (M): And, what happens if the cloth smell bad? How is the girl viewed?

P1: She feels embarrassed, and she is afraid to go out.

M: Um, what are the consequences? I mean how do they handle the distancing, how does the girl take it?

P2: Society is starting to stigmatize you by saying that you stink.

M: Um ... Is it the same for girls who go to school, do they use a piece of cloth?

Room: Yes...

M: And what happens next if these students run out of soap to wash these pieces of cloth?

P1: They miss school until the menstrual cycle ends.

P3: There are even those who drop out of school because they can't stand the humiliation they endure in school.

Social Norm #3: Girls are expected to behave differently after they begin menstruating (Injunctive norm)

We opened the discussion about menstruation by asking participants to tell us what age girls in their communities typically start menstruating. In their responses, many FGD participants also offered up thoughts as to what factors they thought contributed to menarche. Most adolescent and key influencer participants felt that girls start menstruating between 12-14 years old but there was a range of ages mentioned from 9 to 20 years. Factors that were mentioned as contributing to earlier or later menstruation were climate (e.g. perception that hotter climate made girls menstruate earlier), nutrition (e.g. perception that better nutrition leads to earlier menstruation and poor

⁴ Cotex is the brand name of menstrual hygiene pads in Burundi and was the term used by participants to talk about pads.

nutrition leads to later menstruation)⁵, individual biological variation, and being in an urban area where nutrition was perceived to be better (earlier menstruation) compared to a rural area (later menstruation). Some key influencer participants from multiple provinces felt that girls are menstruating earlier now (e.g. age 10-12) compared to when the key influencers were young (e.g. age 17-18).

Injunctive norm and consequences

Most adolescent and key influencer participants across provinces explicitly noted that once girls begin menstruating, they are often considered to have transitioned to adulthood. Sexual debut was often discussed as part of this transition to adulthood. Participants in most FGDs reported that girls typically begin to have sex between the ages of 12 - 15, or soon after they begin menstruating. However, there was a range of ages given for sexual debut; with a few participants expressing that some girls wait until they are older (e.g. 18 or older) while some start having sex as “*early*” as age 9 or 10. For example, an adolescent in Muyinga said,

[Girls start to have sex] Because when a girl starts her period and sees the change in her body like the development of breasts, she thinks that she has become an adult and that she must act like one.

Across FGDs, the idea that there were new social expectations that girls were expected to comply with once they began menstruating also emerged as a major theme. For instance, participants discussed that girls who begin menstruating start to spend time with **other girls** who have begun menstruating. Some participants also mentioned that the onset of menstruation also marks the first time for many girls when they start to receive sexual attention – both wanted and unwanted – from **boys and men**. Girls discussed how it can be challenging to determine how to react to this new sexual attention. This is illustrated by a participant in an FGD with teachers in Gitega,

Here in our community, bike taxi drivers and shopkeepers are wooing these children who are starting to have periods by giving them candy or money in order to seduce them to have sex with them.

And a participant from an FGD with religious leaders in Muyinga said,

When girls start to see their period, they act like adults and that makes boys take an interest in them. And someone can come and test you by telling you that he wants to marry you and if you refuse by insulting or denigrating him, he will go and tell his friends that you are not well educated, which can damage your reputation. It's during this time that the boys are going to want to take advantage of you, giving you gifts like a phone and promising you that they want to marry you. So if you are not well educated you can fall into their traps.

⁵ There is evidence showing that age of menarche is influenced by nutrition [23].

Social norm #4: Sexual activity among unmarried AGYW appears common but socially not approved of (Descriptive and injunctive norms)

Descriptive norm

The majority of adolescent and key influencer participants across FGDs felt that pre-marital sex was common in their communities. When asked what age they think girls in their communities begin having sex, adolescents and key influencers across provinces reported the typical range was between age 12-15. Notably estimates given of age at first sex ranged from 9 to “18 or older” and several key influencer participants felt that girls are starting to have sex earlier now than when they were young. Some participants discussed reasons they felt that girls are having sex earlier. One reason was that onset of menstruation is earlier and a few key influencer participants felt that increased access to “pornographie” via social media or mobile phones was a reason.

Participants were asked about the prevalence of AGYW engaging in several types of sex that could put them at risk of poor health outcomes including transactional sex, unprotected sex, sex with multiple partners and sex after drinking alcohol. Transactional sex and unprotected sex among AGYW were considered very common in the majority of FGDs. Responses about having multiple sexual partners were mixed with participants in about half of the FGDs saying this happens but is not common and about half saying it is common (mainly in adolescent and key influencers in FGDs in Bururi), especially in the context of transactional sex. Having sex after drinking alcohol was viewed as rare in the majority of FGDs. Most participants agreed that in general adolescent girls do not drink alcohol, thus having sex after drinking alcohol was viewed as rare in the majority of FGDs.

Injunctive norm and consequences

Despite the fact that FGD participants spoke about several different types of sexual behaviors as being prevalent in their communities, it was widely agreed in all FGDs that it was considered unacceptable for unmarried girls to engage in sex at all. One adolescent in Bururi stated it concisely: “*It is forbidden to have sex.*”

Participants discussed a variety of negative social consequences that happen to unmarried girls if they are discovered having sex including being called names, being physically beaten, being kicked out of the house and being ostracized by the community. These issues then led to girls having difficulty getting married due to the stigmatization of having already been sexually active and dropping out of school if pregnant. Indeed, many FGD participants discussed that unmarried girls who are known to be sexually active are often considered by the community (**neighbors, parents, family members, teachers, religious communities, peers**) to be badly educated (“*mal éduqué*”) or to lack morals. Girls who have multiple partners, engage in transactional sex, or have sex after drinking alcohol are judged more harshly and are often called prostitutes or derogatory words like “*pute*.” A few adolescent and key influencer participants mentioned that they think that unmarried girls having pre-marital sex is becoming more normalized in their communities, but that even while it is becoming more normalized it is still the case that most AGYW who engage in any sexual activity outside of marriage experience negative sanctions. For example, a participant from an FGD with religious leaders in Muyinga said,

When a girl sleeps with a boy before marriage, and when parents and relatives find out, she is seen as a worthless girl who dishonours herself. She becomes the laughing stock of the village, and everyone points the finger at her. In general, having sex before marriage is considered in our custom as dishonor, but nowadays it is considered normal.

Many participants (both adolescents and key influencers across provinces) described how **boys and men** enforce the norm that it is unacceptable for girls to have sex while also influencing AGYW to act in opposition to this norm. For instance, participants described that boys and men seek AGYW out and sometimes pressure them to have sex (e.g. offering gifts or services, or, less commonly, using alcohol or showing them pornography) but then often when this goal is satisfied, end their relationship, speak of them with derogatory language and refuse to marry them. Two participants in an FGD with ASCs in Bururi discussed,

P1: In the early days, some boys run after her but then they don't care about her anymore!

P2: As she just said, even the boys who would have liked to have her for their fiancée, they can no longer be interested in her, they see her as a whore!

A similar social pressure seems to originate from the value attributed to girls remaining pure and virgins.⁶ For example, a participant in an FGD with ASCs in Muyinga said,

A girl who marries as a virgin, in our Burundian culture, it is an honor for her family and for herself. It's a sign that she followed her parents' advice and the education she was given.

Health providers, including ASCs, were described as serving as both enforcers of the norm that it is unacceptable for unmarried AGYW to have sex and also as social supporters of providing reproductive information and care to AGYW.

In every transcript, unintended pregnancy (*“la grossesse non désirée”*) among adolescent girls came up and was often described as “proof” that girls were having pre-marital or unprotected sex. If premarital sexual activity results in an unintended pregnancy, girls suffer many negative social consequences ranging from having to drop out of school, being kicked out of the house, stigmatized by society, and needing to have transactional sex to support their child. For example, an adolescent in Bujumbura said, *“You often hear about girls who drop out of school because of pregnancy.”*

Another consequence of unintended pregnancy, raised in a few adolescent and key influencer transcripts across provinces, was that sometimes adolescent girls got married to the person who got them pregnant (*“l’auteur de la grossesse”*) at a young age. Sometimes this appeared forced by parents. A typical description of this type of situation in the words of a participant from an FGD with health providers in Bujumbura was:

Parents also influence their children to marry at an early age because a boy can impregnate a girl at age 14-15 and the parents kick her out of the house telling her to go to that boy who got her pregnant. If a child is kicked out of the house, she has no choice but to go to that boy.

Other times it was described that it could only happen if *“l’auteur de la grossesse”* accepted. For example, an adolescent in Bujumbura said, *“[Marriage] happens mostly to girls who have pregnancies, if the perpetrator agrees to take you, you leave regardless of age.”* In one case it was described that *“l’auteur de la grossesse”* demanded it.

⁶ Virginity being held up as a societal ideal may in fact be another social norm that underpins this norm (i.e., social disapproval for unmarried girls being sexually active). However, this did not emerge as a key social norm in our FGDs.

Parents, aunts, neighbors, teachers, health providers, ASCs, and peers were described in most FGDs to encourage AGYW to abstain from sex, and participants viewed this as a form of support. In many cases it appeared that parents, especially mothers, were considered responsible for their daughters' behaviors, both advising them against having sex and monitoring their behavior and punishing them if they find out they have had sex. A teacher in Bururi (who was also a mother of AGYW) said,

In Burundian customs, “indero y'umwigeme itukwa nyina”, the mother is accountable for the success of her daughter's education. But if people speak of the family by saying: the daughter of such she's casting shame on her whole family. So if it's a father who doesn't understand, he's going to take all his anger out on his wife; he doesn't realize that their daughter's behavior depends on both parents.

Health providers, including ASCs, were described as both enforcing compliance with the norm that it is unacceptable for unmarried AGYW to have sex and also supporting non-compliance with this norm by providing reproductive information and care to AGYW. Despite the perceived easy access to contraception, several adolescent and key influencer participants, including health providers, described how some **health providers** counsel girls seeking contraception or condoms to abstain. Some said they counsel girls that if they cannot abstain they should use condoms, and if they cannot use condoms, then they can use a different contraceptive method. For example, a participant from an FGD with mothers of AGYW, who was also a health provider said,

First I asked her to abstain, she replied that sometimes it is difficult for her to resist. If it's difficult, she was offered a condom, because it will protect her against pregnancy and all STIs. She replied “but my darling does not like condoms.” You advise her to tell her darling that if you don't use a condom, I will abandon you because you don't love me, but the girl answers you: no ma'am, we already talked about it. As she insisted, I ended up giving her the method she was looking for.

One exception to people viewing sex among unmarried AGYW negatively was that some community members were described as sympathetic towards girls who were very poor and therefore had sex to meet their basic needs. This exception to the norm was mentioned across provinces in some adolescent and key influencer FGDs. Further, both adolescents and key influencers in about one-third of the FGD transcripts explicitly said that **some poor families** appreciate or even encourage their daughters to have sex with men in order to help support their families, indicating a positive sanction for this type of relationship. For example, a participant in an FGD with teachers in Bururi said,

It depends on the families, suppose the parents are poor, their daughter has a man who gives her money in exchange for sex, and brings home 10kg of beans, a pagne her mother can wear, maybe these parents can appreciate this girl.

Social norm #5: Having sex in exchange for gifts or money is common (Descriptive norm)

Descriptive norm

We asked FGD participants whether it was common for AGYW to have sex in exchange for gifts or money. About three-quarters of adolescent and key influencer FGDs across provinces reported that

this was common among AGYW in their communities and that it was also common for AGYW to have sex in exchange for services or favors (hereafter included in our definition of transactional sex). In the remaining FGDs, participants agreed that AGYW engage in transactional sex in their communities but did not think it was common. In only one adolescent FGD in Muyinga, participants said they had never heard of transactional sex happening in their community. Participants often referred to a partner who gave gifts or money as a sugar daddy (“*papa gateaux*”).

In the majority of adolescent and key influencer FGDs, girls were described as seeking a *papa gateaux* in order to get things they desired that their parents would not (or could not afford to) buy them. Items that were mentioned that girls have sex in exchange for included, (small and large amounts of) money, mobile telephones, food items, shoes, clothes, beauty products (e.g. perfumes, “*de crème de la peau*”). A few adolescent FGDs said that girls have sex in exchange for buying Cotex. Two FGDs with adolescents in Bujumbura mentioned girls being given a car in exchange for sex. Some participants in some FGDs mentioned exchanging sex for services or favors such as moto rides, purchases at a boutique, haircuts, or getting better grades. Having transactional sex was sometimes described as leading some girls to have multiple partners. For example, an adolescent in Bujumbura described,

In my opinion, there are girls who say to themselves: “I have to have a lot of partners; one will give me 100 USD and I will go to a nightclub with friends; the other will buy me a car. So I wouldn’t be the same as my friends who have only one guy”. So the girl feels like an adult at a higher level. Also, they are happy to have the money and to go get a manicure or make up. This is what pushes girls to have multiple partners.

Many participants in most FGDs said that seeing other **girls or friends** with nice things made some girls want to have these nice things which led them to seek out a *papa gateaux*. Sometimes, however, it was reported that if girls have been severely ostracized or stigmatized for pregnancy out of wedlock, they end up resorting to transactional sex to meet their basic needs. As described by two adolescents in Bujumbura,

P1: For example, rations, you do not have salt because in our community if you have become a girl mother, your mother hates you, your brothers also ask you to leave the house, that you are responsible for your problems and then you find yourself in this situation of having sex to get something to eat.

P2: After you get pregnant, the perpetrator of your pregnancy becomes irresponsible and you become a sex worker so that you can dress your child and yourself.

Many participants in most FGDs said that **boyfriends/partners or papa gateaux** expect or pressure girlfriends to have sex with them, especially if they give them gifts. In some cases, especially among key influencers, **men who gave gifts, money or services** (e.g. moto rides) were described as badly intentioned (“*mal-intentionné*”) or as seducing or tricking girls with gifts, money or services that they did not have the means to buy. A participant in an FGD with ASCs in Bururi described,

A girl from a poor family may want to imitate her friends, wanting to wear clothes that are fashionable. Since these boys cannot give her these gifts for nothing, they coerce her, giving her an example of other girls who wear nice clothes and the latter will follow unintentionally!

Social norm #6: Instances of coerced sex appear common and girls who experience sexual violence are typically socially shamed (Descriptive and injunctive norms)

Descriptive norm

Most adolescent and key influencer participants in most FGDs thought that forced sex or rape (“*viol*”) was infrequent in their communities. Although we did not use the word rape on the discussion guides, most of the FGDs discussed forced sex and rape interchangeably. Participants, mainly adolescents, cited various circumstances where rape may occur by a stranger, however this was usually perceived as rare. In a few FGDs, participants talked about boys forcing girls to have sex after girls initially refused to have sex with them. Additionally, most participants felt that physical violence from partners (e.g., beaten or hit) was rare. The few that did think it happened stated that sometimes male partners get jealous of their girlfriends and hit them (“*frapper*”).

Despite participants expressing that they perceived rape and physical violence from partners to be rare in almost all adolescent and key influencer FGDs, participants described multiple examples of pressured sex. In addition, although the question was asked about pressured sex, many of the examples that participants gave in response to this question, described instances of what we felt met the definition of sexual coercion. Sexual coercion is generally defined as instances of sexual pressure that include a power differential [24]. When asked how common occurrences of pressured and coerced sex were in their communities, participants had mixed perceptions ranging from rare to very common. In describing situations of coerced sex, FGD participants across provinces typically described the instigators of these occurrences as: men in positions of authority in the community and men, (e.g. partners and sugar daddies) who offered girls money, services or gifts in return for sex (described in the previous section Social norm #5).

The most commonly mentioned men in positions of authority who coerced girls into having sex were **teachers/professeurs**, mentioned in more than half of FGDs (both adolescent and key influencers across provinces, including the FGDs with teachers). In these transcripts, participants described how teachers sometimes coerce girls to have sex to improve their grades or pass their class. In some cases, this was considered common, whereas in other cases it was described to be uncommon. Adolescents in an FGD in Gitega discussed this issue and felt it was common in their community:

P1: There is something else going on in schools, the teacher has a great influence on you and tells you that you will not succeed if you do not agree to do it with him.

P2: And instead of failing you accept.

Mass response [laughter in the room]: It happens often, it is frequent.

Several adolescent and key influencer FGDs across provinces mentioned that employers (most commonly “*le patron*” of a house where a girl babysits or serves as a “*bonne*”) coerced the babysitter or *bonne* to have sex with them. A few FGDs mentioned police, guardians or men in houses where a female student is lodging, “*married men*”, “*older men*”. In two transcripts each, pastors, doctors and local administrators were mentioned as coercing girls to have sex.

Injunctive norm and consequences

Participants in more than half of adolescent transcripts and three-quarters of key influencer transcripts described how adolescent girls who experience pressured, coerced or forced sex are often, or fear being, stigmatized, discriminated against, shamed or blamed by peers and community members in general. In addition, FGD participants described that AGYW are likely to keep these experiences secret because they don't feel that anyone will believe them and rather that they will be blamed instead. For example, a participant from an FGD with local administrators in Bururi said, *"I think they are scared because people can say she was the one who caused this and also they think it is something to be ashamed of."* An adolescent from an FGD in Bururi said, *"Others say she was the one who wanted to be raped."*

Sometimes participants described how a girls' reputation influences how people would treat her if she experienced such an incident. For example, a participant from an FGD with local administrators in Bujumbura said,

It depends on the child victim because if there is a girl in the community who is known to not date men. If this happens to her, she is rushed to the hospital for protection. But, if it's a girl known in the community for dating men often or having sex partners, there in the community, they say it was her fault that it happened to her.

Furthermore, in the framing of descriptions of coerced sex it was apparent that many participants (adolescents and key influencers) perceived girls themselves to typically be responsible for the occurrence of these events. Even if participants acknowledged that men were sometimes badly intentioned (*"mal intentionnés"*) they believed the girl had bad behavior (*"mauvais comportement"*). For example, a participant from an FGD with local administrators in Bururi described,

Generally speaking, young girls have sex with those who give them money, clothes, even lifts they get on motorcycles! Men with bad intentions use these means to take advantage of these young girls and after they get what they want, they let them down... The ones who do this are the girls who behave badly.

Related to the idea that girls were considered responsible for all types of sexual violence, in the problem tree exercises, girls dressing *"indecently"* (e.g. wearing *"mini-skirts"*) was one of the main root causes of sexual violence that was discussed by key influencer FGDs (*"The first root cause is indecent clothing."*-Local administrator FGD, Bururi).

In only a few FGDs, participants described that the **community, family members, or peers** would support or stand behind a girl who reported experiencing sexual violence. For example, one participant from an FGD with ASCs in Muyinga said that girls who ask for help are considered heroes since they *"dared"* speak about sexual violence: *"Those who are over 16 years old participate in speaking out to ask for help. We consider them as heroes, those who dare to say what others cannot say."*

In most adolescent and key influencer FGDs across provinces, it appeared that those who pressure or coerce girls into having sex do not get punished but those who rape a girl might. In just over half of transcripts (mainly key influencer transcripts) across provinces, participants discussed different sanctions that men who raped a child or girl could face, most commonly mentioning that they could be arrested or imprisoned. However, it was not clear if this happened beyond a few anecdotal stories,

or if they felt that it could or should happen. Other sanctions that perpetrators could face that were mentioned in a few transcripts each, were being fired or losing a license (teachers), having to pay a fee, being shamed or punished by the girl's parents, or even sometimes having to relocate out of the community. In some cases, participants said that there would have to be "proof" of the incident for the perpetrator to actually be punished. In terms of "proof", it seemed that participants were referring to the victim getting pregnant.

Social norm #7: It is becoming less common and less socially acceptable to have more children than one can care for (Emerging descriptive and injunctive norms)

Descriptive norm

Adolescents were asked what their ideal number of children would be and the majority of key influencer FGDs were asked what the typical family size is in their communities. Most adolescents responded that having 3-4 children would be ideal and this did not differ by province. Key influencers said that most families in their communities had an average of 5 children per family (range 2-12 children) across provinces. The fact that AGYW now aspire to having fewer children than their parents (3 versus 5) seems indicative of a change in this norm.

There was also a general sentiment among key influencers that families used to be bigger (e.g. 8-10 children) and are now smaller (e.g. 5 children), which was mostly attributed to life becoming more expensive. Several adolescents also noted that there was less land now to raise many children and a few adolescents in two FGDs in Gitega stated that the government now says you should only have 3 children due to lack of land.⁷

Injunctive norm and consequences

As families are beginning to have fewer children and experiencing economic pressures to do so, normative expectations of appropriate family size similarly appear to be changing. In some of the FGDs participants described that some people in the community still desire large families, but there was discussion of a new norm of appropriate family size beginning to emerge. For instance, several adolescent and key influencer participants stated that some people desire larger family sizes and view having many children as a blessing ("*bénédiction*"), and other participants mentioned that some **churches or the Bible** say that people should "*multiply like the sand in the sea*". However, many participants in those same FGDs noted that it is becoming less acceptable to have many children even among **religious communities**. For example, a participant from an FGD with religious leaders in Muyinga described, "*Because if you give birth to a lot of children that you cannot support, that is also a sin and that is why family planning methods are used.*"

A few participants mentioned negative social consequences of having more children than you can take care of such as **community members** talking about you and wondering how you could care for so many children. For example, a participant from an FGD with mothers of AGYW in Bujumbura

⁷ Note that the government of Burundi has adopted a strategic objective to lower the fertility from 5.5 to 3 children per woman by 2025 [25-27].

said, " Yes, it's between 5 and 6 children, if you exceed that number, the community will start talking: 'how are they going to take care of these children?' ". Smaller families were discussed in some FGDs as being more "modern" and sometimes planning one's family was described as "civilized".

Social norm #8: AGYW do not typically use contraception and it is not considered appropriate for them to use contraception (Descriptive and injunctive norms)

Descriptive norm

Most adolescent and key influencer participants in most FGDs across provinces reported thinking that AGYW do not typically use contraceptive methods or condoms. Several adolescent and key influencer participants in most FGDs commented that if AGYW do use contraceptive methods, they keep it a secret. Some participants in many FGDs pointed to the existence of unintended pregnancies among AGYW as "evidence" that AGYW were not using contraception. For example, an adolescent in Bururi said,

In our region, several girls are unmarried mothers and I tell myself that if they had used [contraceptive] methods, they would not have had children. Hence my assumption that they do not use contraceptive methods.

Injunctive norm and consequences

In about two-thirds of the transcripts across provinces (except the adolescent FGDs in Bujumbura who were not asked about social consequences of girls using FP and did not mention any), participants said that unmarried AGYW who use contraceptives are viewed negatively, stigmatized or called names, most commonly "prostitute" by others in the community. As discussed, by two adolescents in Gitega,

P1: If they get to know her, they say she is a prostitute; and if your mother has ever seen you with her knowing that she uses [contraceptive] methods, she will forbid you from hanging out with her, afraid you will behave the same way.

P2: They start to stigmatize her, and if a boy starts flirting with her, he tells her that if he ever takes this girl, he won't have a child. That the methods can cause infertility.

In more than three-quarters of key influencer transcripts and a few adolescent transcripts across provinces, participants explicitly stated that use of modern contraception is unacceptable in the eyes of the **church and church congregation members**. Specifically, they said that some **churches** (Catholic, Protestant and Pentecostal were all mentioned) teach that using family planning is a sin or even as killing children. As a result of this, many of these participants stated that people in general, including married women, often use modern contraception secretly, and some, especially Catholics believe that it is only acceptable to use natural methods. For example, a participant in an FGD with teachers in Bururi said, "For those who are married, they hide [their FP use] because of their religion, as other Christians might think she does not agree with their principles." This was often cited as a major barrier to women and AGYW using FP.

Most adolescent and key influencer participants across almost all transcripts said that contraceptive methods are available at health facilities and equated availability with AGYW being able to obtain

them. Despite this sentiment, most adolescents and key influencers described how girls fear being seen accessing contraception. So, these girls either do not access contraception, go to another community to access it, or have a friend access it for them. Some adolescent and key influencer participants across provinces specifically talked about how some **health providers** do not give contraception to unmarried or childless AGYW, resulting in girls sometimes lying about already having a child or being married so they can get it. For example, two adolescents in Muyinga discussed,

P1: Several girls use contraceptive methods, they go to ABUBEF, but it is difficult to get them if you are unmarried, some cheat by saying that they already have a child in order to be able to get some.

M: Anyone want to add?

P2: Other girls even use injectables and implants, just lie that you're married, as providers don't ask for a marriage certificate.

In general, most AGYW and key influencer participants in most FGDS expressed an expectation that girls who are “unable to abstain” should be using condoms. Some participants said girls are considered smart (“*intelligentes*”) if they use condoms. Most participants felt that condoms are accessible, but that AGYW, especially younger AGYW, often had unprotected sex, mainly because **partners** refused to wear them. And in the case of *papa gateaux* or boyfriends who gave them things, many FGD participants mentioned that these male partners felt justified in refusing to wear condoms since they were giving girls gifts. Sometimes it was described that girls felt scared to ask for their partner to use a condom for fear that they would leave them.

Health providers, including ASCs (in the transcripts excluding the Bujumbura transcripts), were the most commonly mentioned source of support for AGYW regarding providing information about FP and contraceptive methods, mentioned by almost all participants across provinces. Despite the provider bias noted above, health providers generally viewed FP use among AGYW more positively compared to other groups. Several key informant FGD participants gave examples of different healthcare settings or health providers who warmly welcome AGYW in accessing FP services for example by respecting their confidentiality (in a private room) or offered fast care so girls could leave without being seen. Some participants described how ASCs also have dedicated hours to talk to AGYW or private community sensitization meetings for girls. Participants in several key influencer FGDs across provinces described how health providers are expected to welcome everyone (“*tout le monde*”) and offer RH and voluntary FP care to anyone seeking them. For example, a participant from an FGD with mothers of AGYW in Bujumbura said,

[Adolescent girls] have no problem, they get the methods they want. There is an order to providers that says that you should not refuse anyone who wants to have a contraceptive method, that you should give advice to all beneficiaries.

Alternatively, some adolescent and key influencer participants mentioned that some community members, usually **health providers or ASCs**, had positive views about unmarried AGYW using FP, such as avoiding unintended pregnancies while still living at home or so that they can stay in school. For example, an adolescent in an FGD in Bururi described, “*even your parents appreciate you and prefer that you use these contraceptive methods instead of continuing to give birth.*” And a participant from an FGD with local administrators in Bururi spoke positively about ASCs educating girls about condoms and FP and hopes they use them in the future, “*ASCs are at work, which is why*

we are hopeful that these children will use these contraceptive methods when they consider having sex.”

A few key influencer participants made statements about how they think things may be changing in terms of social support for girls being able to use contraceptives. For example, a participant from an FGD with local administrators in Bujumbura said,

Before, the community did not understand how a girl could use a contraceptive method. But, currently, if you see a girl who has condoms or with an implant in her arm, you find this girl to be very smart because she protects herself against unwanted pregnancy.

Key influencers

In all of the FGDs involving AGYW, across the four domains of inquiry a large array of different types of people were mentioned by participants as influencing the eight key RH norms that emerged in the FGDs. The key influencer groups that we were able to enroll in FGDs discussed the same large array of influence groups. Parents, health providers (including ASCs), peers and friends, sexual partners, teachers, religious leaders, neighbors and other family members were the most commonly mentioned groups that influenced these norms.

In our analysis, we noted that the influence that these groups exerted on girls ranged from enforcing norms to supporting non-compliance of norms. We also noted that some influence groups were named substantially more frequently than others while some groups albeit named infrequently were discussed as having substantial influence. For example, health clubs were only mentioned as giving girls information about RH in a few transcripts, but for girls who had access to a health club it appeared to be an important source of needed information.

Based on these observations, we organized the influence groups that were mentioned on a spectrum of influence that took into account type of influence as well as the strength of influence as determined by both frequency and saliency of how the groups were discussed. This categorization is shown from left to right in Table 7, with the green columns including those who support AGYW's non-compliance with these norms. The red columns show those who enforce compliance with these norms. The columns on the far left and far right show those who were mentioned as having the strongest influence whereas those in the interior two columns were less commonly mentioned or did not appear to have as much influence.

With an eye to future intervention work with these different groups, we further organized the influence groups mentioned according to proximity to the individual AGYW. For this organizational structure, we conceptualized a multi-level social ecological model to depict how the individual AGYW whose RH behaviors are of interest are nested within layers of influence. We regarded interpersonal relationships with family members and sexual partners as being the closest relationships to AGYW and therefore placed those at the top of the table as the closest level of influence. Below that, we placed the influence groups with the larger community based on both the frequency with which they are likely to interact with AGYW and the level of authority they seem to hold in the community.

Table 7. Key influence groups organized by level and spectrum of normative influence (i.e., type and strength)

Level of Influence	Spectrum of Influence	Supports non-compliance with the norm – strongest influence	Supports non-compliance with the norm – some influence	Enforces compliance with the norm- some influence	Enforces compliance with the norm- strongest influence
Interpersonal level influencers	Household				
	Parents^a	(Mothers) Talk to girls about menstruation (Mothers) Help girls with menstrual hygiene management Bring girls to health facility if experienced rape	Support AGYW using contraception	Encourage or support girls to have transactional sex	Don't talk to girls about menstruation, RH; some oppose health workers talking to girls about RH or giving AGYW contraception Expect girls to self-regulate to avoid sex View/treat AGYW negatively if they have had sex Judge/stigmatize girls who have experienced sexual violence
	Older sisters, aunts	Talk to girls about menstruation, contraception	Support girls using contraception	View/treat AGYW negatively if have had sex	Expect girls to self-regulate to avoid sex
	Sexual relationship				
	Sexual partners, boyfriends, sugar daddies			View/treat AGYW negatively if they are known to have had previous sexual partners Oppose AGYW using contraception	Pressure/coerce girls into having sex in exchange for gifts or money Refuse to wear condoms
Community level influencers	Neighborhoods				
	Neighbors		Bring girls to health facility if experienced rape		Expect girls to self-regulate to avoid sex View/treat AGYW negatively if have had sex Judge/stigmatize girls who have experienced sexual violence Don't talk to girls about RH; some do not like health workers talking to girls about RH
	Schools/peers				
	Female friends/peers	Talk to girls about menstruation, contraception Help girls with menstrual hygiene management Bring girls to health facility if experienced rape	Support girls using contraception		Ridicule/shame girls with menstrual stain or odor at school Expect girls to self-regulate to avoid sex View/treat AGYW negatively if have had sex Encourage/influence girls to have transactional sex Judge/stigmatize girls who have experienced sexual violence
	Male friends/peers				Ridicule/shame girls with menstrual stain or odor at school Seek out girls for sex then treat them negatively if they have had sex

Community level influencers					Coerce, pressure or force girls to have sex Judge/stigmatize girls who have experienced sexual violence
	Teachers ^b	(Female teachers) help girls with menstrual hygiene management	Teach girls about menstruation, FP/RH		Don't talk to girls about RH Some male teachers coerce girls to have sex with them in exchange for passing a class or an assignment View/treat AGYW negatively if have had sex
	Health clubs/peer educators	Teach girls about menstruation, RH Give info about sexual violence (e.g. where to get services)	Support AGYW using contraception		
	Churches and mosques				
	Health providers and ASCs, hospitals and health centers	Provide info to AGYW on RH Give info on sexual violence and support (e.g. medical treatment) for survivors Support AGYW to have safe sex (e.g. provide info and contraception)		Some doctors coerce girls into having sex	Expect girls to self-regulate to avoid sex Some view AGYW negatively if they use FP Some withhold SRH info and services to AGYW beyond counseling on abstinence
	Health sector				
	Religious leaders and congregation members (most commonly churches, rarely mosques)	Some support limiting number of children to number one can take care of and support FP use	Provide information to AGYW on RH Speak out against sexual violence (adultery and rape)	Some pastors coerce girls into having sex	Don't talk to girls about RH View and treat AGYW negatively if they have had sex Some churches teach that FP is a sin/murder Some promote having many children
	Other community authorities and organizations				
	Community authorities (chefs de colline, local administrators, etc.)	Speak out against sexual violence, enforce sanctions against perpetrators			Expect girls to self-regulate to avoid sex Some police, local administrators coerce girls into having sex
	Child rights/protection committees, Women's associations, NGOs, Community center	Give info/services about sexual violence			Some view/treat AGYW negatively if have had sex

^a Though participants spoke about "parents" generally, they were often specifically referring to mothers. In this table, mothers were only explicitly mentioned if participants explicitly mentioned mothers.

^b Teachers' gender is noted when it was mentioned by the participants.

KEY LEARNINGS

This is the first study to document social norms that impact unmarried AGYW's RH behaviors in Burundi and among the first to do so globally. In addition to the important documentation that this study provides, we reflect in this section on several key learnings that will inform future research and programs in this area.

Key learning #1:

The existence of a large variety of influence groups who play multiple roles in both upholding norms in the community and in the lives of the target population is an important consideration not only in the interpretation of our findings but also for all future social norms research and interventions.

It was notable to us that although a few influence groups were discussed as having influence in only one or two domains (i.e., local administrators and authorities only were discussed as having influence with regards to the occurrence or mitigation of sexual violence) the majority of influence groups were mentioned as having influence in more than one domain of interest. Furthermore, with the exception of a few key influencer groups, the majority of key influencer groups that emerged in the FGDs were described alternately as enforcing compliance with social norms and in providing information and support to AGYW that would support non-compliance with the norms. For example, health providers and ASCs were most often described as providing AGYW with RH information or care, but also sometimes as withholding RH information or care from AGYW, thereby enforcing compliance with injunctive norms. Similarly, some teachers were described to be sources of support for information on RH, while some male teachers were described to coerce girls into having sex with them in exchange for better grades or to pass a class.

Also worth noting is that many of the key influencer participants could be categorized under more than one key influencer type. For example, mothers of AGYW were also teachers or health providers, ASCs were sometimes also teachers. As a result, when these participants spoke in first person their views reflected experiences and opinions not only from the point of view as the influencer type that they were recruited to represent, but also from the point of view of the other key influencer type that they represented. The fact that these individuals play more than one role in the lives of AGYW further adds to the complexity of relationships between target groups and influencers.

As noted in the methods section, we chose to use the term “influence group” in this study. However, we did not distinguish between positive and negative influence and we noted that in most discussion groups, influence was interpreted largely as supportive influence. It is therefore possible that we missed the opportunity to interview some key influence groups who influenced in less supportive ways. For example, in most FGDs, men and boys were clearly described as having significant influence, largely as enforcers of norm compliance, however they did not make the list of key influencers that were voted upon. It was also of interest to us that certain reference groups, namely grandmothers and fathers, that have emerged as influential in the lives of women and children in similar contexts [28, 29] were not explicitly mentioned as key influencers by our participants. We suggest that future exploratory studies use precise language to ask separately about differing roles played by influence groups.

Using one term, whether reference group or influence group, seems inadequate to the large variety of individuals who influence AGYW and the fact that many individuals play more than one role in the lives of AGYW. Future formative research should ask multiple questions to clearly elucidate different groups and their roles. The fact that multiple influence groups exist and that many of these groups both enforce harmful norms and provide support for going against harmful norms also has two important implications for intervention design and implementation: 1) interventions should be designed to involve multiple groups with differing amounts of social status and power, and 2) many of these groups need to receive simultaneous encouragement of the positive roles that they play and approaches to minimize and redirect the ways in which they enforce harmful norms.

Key learning #2:

By using a rigorous multi-step approach to identifying and engaging key influencer groups, we were able to engage and reflect a wide array of influence groups with differing perspectives on these issues.

In our study, we began with FGDs with unmarried AGYW and in those groups asked the participants to name the groups of people they felt had the most influence on each domain of inquiry. After completing the AGYW' FGDs in a province, our study team met to review the key influencers named and select key influencers to recruit for the next wave of FGDs. Our determination of influence groups to recruit was based on three key criteria: 1) the number of votes received by the AGYW participants; 2) the feasibility of successfully recruiting that group of individuals; and 3) the new insights that that group would bring to the study. In terms of new insights, prior to the selection of influence groups in each province, we assessed how many of that type of influence group had already been interviewed and each time sought to include sufficient numbers of that type of group to ensure saturation of study themes with that group. We also sought to recruit new influence groups so as to include a broader representation of community perspectives.

By letting the AGYW both define who influenced their behaviors and beliefs and who they deemed to be the most important influencers we were able to quickly prioritize which influence groups to recruit for study inclusion. Furthermore, by systematically pausing and taking into account whether that group's perspective had already been incorporated in the data collected, we were able to ensure not only that the perspectives of the groups deemed most influential were incorporated but also that we reflected a diversity of perspectives on the same issues. To the extent that the information shared by different key influencers usually reinforced what AGYW and other key influencers said, this triangulation of the data (i.e., convergence of information from different sources) helped us to test the validity of our findings.

In terms of feasibility, we note that a challenge we faced was the availability and accessibility of certain groups of key influencers. In particular, in our study, the police and doctors were named and received substantial votes in some provinces as key influence groups but we were told that we were not authorized to invite police to participate in an FGD and that doctors would not be available to participate in our study. We recognize that our inability to engage these groups limits our findings in as much as the perspective of those groups are not reflected here. However, this limitation is not unique to this study as recruitment biases are present in the majority of social-behavioral studies.

Key learning #3:

Despite significant discussion and recognition of norms for adolescent girls' FP/RH existing in the larger social context, AGYW and key influencers in this study placed significant onus on individual AGYW to comply with the norms as well as held them individually responsible for not complying.

Across FGDs, both adolescent and key influencer participants in all provinces often spoke in a manner that implied that they think of AGYW as having considerable agency across all behavioral domains of interest. AGYW were expected to know how to manage their menstrual hygiene, avoid unprotected sex (e.g. negotiate condom use with male partners), and avoid sexual violence. Several participants made statements about how girls should simply follow their parents' advice to avoid sex implying that they had full control over their circumstances.

It was also clear in the FGDs that AGYW themselves were held personally responsible for failure to comply with descriptive and injunctive social norms. For example, FGDs unearthed a variety of negative social consequences that fall on AGYW if they fail to comply with descriptive and injunctive social norms. For example, girls are ridiculed or stigmatized if they have poor menstrual hygiene or are viewed negatively and treated badly if they have had sex out of wedlock. Additionally, participants in most adolescent and key influencer FGDs described negative social consequences for girls who refused to have sex with men in societal positions of power, ranging from failing a class, to losing financial support or even a job. However, if they did have sex under these circumstances, they were also judged harshly as being weak (“*faible*”) or badly educated (“*mal-éduquée*”) by the community or peers who found out about this. For example, a participant in an FGD with ASCs in Muyinga said:

There are schools where a teacher puts pressure on a student he is teaching by telling her that if she does not agree to sleep with him, she will not be able to pass the class. In this case, a weak girl who is afraid of failing has to accept what this teacher asks.

Instead of supporting AGYW who have experienced sexual violence, community members often stigmatized or blamed AGYW as if they had let this happen to them.

Finally, it was also clear in the FGDs that in many situations AGYW do not have sufficient information to make informed choices, nor the support, power or agency needed to act independently and make their own free choices. For instance, many AGYW lack information about menstruation and contraception but then are blamed for poor menstrual hygiene management and unintended pregnancies. AGYW also typically lack the power to negotiate condom use with male partners who not only are likely physically stronger than they are but also typically are older and have greater social status than they do. Despite the power differentials existing between AGYW and most of their male partners, AGYW were criticized for not using condoms. As expressed by a participant from an FGD with peer educators in Bururi,

Girls are weak. They can ask their partners to use [condoms], and the partners refuse and choose to leave them. But these girls are going to say, okay let's do it! You understand that they are the ones who will suffer the consequences!

RECOMMENDATIONS ON NORMS-SHIFTING INTERVENTIONS

In this study, we asked unmarried AGYW and other influential community members not only what RH behaviors AGYW typically engage in in four provinces of Burundi but also which of these behaviors are socially approved and disapproved of. In the process of so doing, we identified the existence of eight different social norms which influence AGYW's RH behaviors and outcomes. Furthermore, we found evidence that AGYW alone lack sufficient agency and social power to be able to choose individually not to comply with these norms. Rather, we found that across all of the behavioral domains of interest, a variety of community members of differing social statuses and positions of power enforced these different norms.

Norms-shifting interventions typically:

- Seek community-level change (outcomes beyond the individual level)
- Emphasize creation of positive new norms
- Engage a wide range of people at multiple levels
- Create safe spaces for critical community reflection
- Confront power imbalances
- Root the issue within the community's own value systems
- Use organized diffusion (begins with a core group who then engage others)
- Are based on accurate assessment of social norms
- Correct misperceptions around harmful behaviors

Figure 3: Nine Key Attributes of Norms-shifting Interventions

Given these findings, it is clear that to improve the RH and well-being of AGYW in Burundi it will be necessary to implement interventions that extend beyond individual-level behavior change and beyond providing education and care and explore ways that programs can shift norms at the community level. Distinct from other types of behavior change interventions, community-based, norms-shifting interventions have been defined as interventions that “seek to improve the RH of women and girls and men and boys, at least in part by transforming the social norms that prop up harmful health-related behaviors”[30]. A review of the literature has shown that effective norms-shifting interventions commonly include at least several of a set of nine key attributes that are listed in Figure 3.

Below we outline five specific ideas for potential entry points and accompanying strategies for future interventions to shift the norms and engage

the key influence groups identified in this study. To determine which strategies to recommend, we brainstormed and compiled a list of known recent norms-shifting interventions for AGYW in LMICs. We then noted which norms and reference groups each of these interventions addressed as well as which strategies they used to do so. We then selected intervention strategies that seemed to have the greatest applicability to the norms and reference groups identified in this study as well as seemed most novel or relevant for the Burundian context. While we focus here on suggestions for norms-shifting interventions, norms-shifting interventions are often most effective when complemented by other behavior and structural change strategies. Our findings indicate that strategies, such as income-generating activities to address poverty and girls' agency and the design of more youth-friendly RH programs, would also address other factors that affect RH behaviors and outcomes.

Table 8. Intervention ideas to address the norms identified in this study

Idea #1: Create positive new norms for more open discussion of sexuality, menstruation and RH with family members
Idea #2: Create safe spaces and improved access for AGYW to become informed about sexuality and RH
Idea #3: Confront gender and power imbalances contributing to sexual risk
Idea #4: Engage religious leaders as champions for voluntary FP
Idea #5: Explore underlying drivers of health workers' bias

Idea #1: Create positive new norms for more open discussion of sexuality, menstruation and RH with family members

In this study we found that discussion of sexuality, menstruation, and RH was not normative (social norm #1). Reluctance about and discomfort with openly discussing these issues is normative in many cultures and social contexts. However, in our study, the negative social consequences that result from this norm were often quite serious (i.e., stigma and poor menstrual hygiene management) and parents were most often cited as a key influence group for enforcing these norms with sanctions for non-compliance.

At the same time, **parents – mothers** in particular – were simultaneously described as being a prime/key source of information on RH behaviors and it is well established that girls worldwide typically look to their mothers as role models and sources of support as they transition to adulthood. We suggest that the critical and dual role that mothers play in upholding this norm provides a window of opportunity for interventions that engage parents as allies in establishing positive new norms. Some adolescent and influencer participants expressed similar sentiments, “*we ask that there also be teachings in families so that they do not regard sexuality as a taboo subject*” –Health provider FGD, Gitega

One approach that may be well-suited to establishing positive new norms for discussing sexuality, menstruation and RH is the approach that has been taken by the Adolescents 360 program in Tanzania [31, 32]. To shift social norms around RH behaviors, the program brought **parents** together in discussion groups and asked them to reflect on their own adolescence to help them relate better to the challenges their daughters were facing. Simultaneously, the program created a combination of *Know Your Body* classes followed by private counseling with youth-friendly providers to serve as a safe entry point for adolescent girls (ages 15-19) to learn about their bodies, puberty and reproduction. The combination of these group reflection & educational activities allowed **parents** and daughters to reframe the idea of openly discussing RH issues as a positive behavior rather than as a taboo subject.

In our study, **other family members, particularly older sisters and aunts**, were also commonly mentioned by adolescents as sources of support. We would imagine that in a similar fashion, these family members could also be engaged in the establishment of these positive new norms. For instance, if a social norm of giving girls' input about healthy living at developmental milestones, such as menstruation, were developed (social norm #3), other family members could also be educated and enrolled as allies in this effort.

Idea #2: Create safe spaces and improved access for AGYW to become informed about sexuality and RH

We found that girls were often uninformed and unprepared for menstruation (social norm #1). In addition, when girls begin menstruating, because they were unprepared, they were often shamed and stigmatized by their male and female peers for not having proper menstrual hygiene management (social norm #2). Boys were also cited as instigating sexual risk behaviors and perpetuating social norms of shaming unmarried girls who engage in sex (social norm #4). Much of this shaming and instigation of risk behaviors occurred in schools and furthermore teachers were not always a reliable source of support, resulting in schools not being a safe space for girls. Giving young girls accurate information before they begin menstruating or become sexually active and engaging male and female peers around healthy RH social norms at young ages presents an opportunity to prevent more harmful normative behaviors from developing.

One opportunity for providing girls with accurate information, which has been identified as a high-impact practice for social and behavior change in family planning by a technical advisory group of international experts [33] as well as shown to contribute to social norms change [34], is use of digital technologies. Specifically, in light of the fact that AGYW in our FGDs discussed mobile phones and that young people especially are using digital technologies to access information at rapidly increasing rates, consideration should be given to making effective use of mobile phones and internet to provide accurate information to AGYW when and where they want it. Another advantage of this approach is that if designed carefully to do so, information can be accessed with confidentiality, privacy, and anonymity—issues that are critically important to young people. An example of successful use of digital technologies to reach young people and increase knowledge of RH is Mobile for Reproductive Health (M4RH)[35].

Another approach that has focused on intervening among very young adolescents and engages boys, teachers, schools as well as a wide range of other community members to create safe spaces for AGYW is the *Bien Grandir!* (Growing up GREAT!) intervention in Kinshasa [36]. The program aims to increase adolescents' knowledge of puberty and reproductive development; and use of FP/RH care as youth age into older adolescence; as well as gender equitable behavior of adolescents and parents and community members. Both in-school and out-of-school youth ages 10-14 years old participate in weekly meetings of mixed sex youth clubs. In-school adolescents participate in self-facilitated school-based clubs led by trained peer leaders, while out-of-school youth participate in community-based clubs led by trained facilitators from local community-based organizations (CBOs). One session is led by a health provider trained in providing adolescent-friendly health care, and each club visits the nearest facility to foster health system linkages and reduce stigma. **Teachers** also serve as resources for adolescent **school clubs** and mentors for club leaders. School-based activities are intended to reach beyond club members to support diffusion of new ideas and encourage social norm change. **Parents** of club members participate in a series of discussions led by trained facilitators from CBOs using testimonial videos featuring parents in their communities who have adopted target behaviors related to gender, girls' education and communication about puberty and sexuality; parents then discuss the social norms underlying and driving health behaviors. Finally, community members are invited to participate in an interactive game to explore norms around adolescent health and gender, and to view and reflect on the video testimonials developed for parent sessions.

After one year of implementation of *Bien Grandir!*, results indicated that the intervention appeared to be particularly effective at improving key outcomes among younger participants as well as effective in shifting norms about gender for household roles and improving communication, awareness and perceived access to contraception. A similar program, "Programme Conjoint pour la Promotion de la Santé Sexuelle et Reproductive des Adolescents et Jeunes" was launched for young people aged 10-24 in multiple locations throughout Burundi in 2017 and is currently being evaluated. Their baseline survey showed that knowledge and access to RH care for adolescents and youth were not satisfactory in Burundi [37]. In a similar fashion, YouthPower Action implemented a program which created a safe space for young girls ages 10 -18 using a mentoring approach for girls to learn about health and feel supported by older adolescents and young women (ages 18-25)[38]. The Enhancing Outcomes for Adolescent Girls and Young Women in Bujumbura Mairie, Bujumbura Rural and Gitega, which was focused on the goal of reducing HIV risk and improving treatment for girls living with HIV, served more than 10,000 girls and included girls and caregivers in economic strengthening activities that resulted in reducing intergenerational sexual relationships since households were able to meet their basic needs. These types of multi-level, multi-sectoral approaches that create safe spaces for youth, and address gender and power imbalances at an early age seem well-suited to engage the influence groups and address the social norms identified in this study.

Idea #3: Confront gender and power imbalances contributing to sexual risk

In the FGDs in this study, participants predominantly perceived sexual violence as rare in their communities. This is a positive finding in light of the high prevalence of sexual violence and rape reported in Burundi in the aftermath of its civil war [7]. This may also be influenced by local conceptions of what constitutes rape. In a survey conducted in Burundi in 2014, 89% of men and 93% of women said that if a victim did not physically fight back, it was not rape [39].

Coercive sex and transactional sex were however described as common behaviors (social norms #4, #5 and #6). There are varying definitions of what constitutes sexual violence but most include any sexual act using coercion [24, 40]. The impact of sexual violence ranges from short-term trauma to longer term issues, including unintended pregnancies, which was documented in a recent study among young women in Burundi [6] and also raised as a concern in our FGDs. In the FGDs, participants often described transactional sex alternately as a behavior that girls chose to pursue as well as, in other instances, something they were coerced or pressured to engage in. Whether or not transactional sex is considered exploitative has been shown to vary across cultural contexts depending up normative expectations of gender and exchange [41]. A recent study conducted in Tanzania documented that transactional relationships in that context were considered exploitative when the encounter or relationship involved an imbalance of power (based on age, economic power and social status) [41].

In the FGDs, it was often described that the men involved in instances of transactional and coercive sex were substantially older, had greater economic or social status (i.e., *papa gateaux*), and were in positions of authority relative to the AGYW (i.e., teachers) as well as within the larger communities (i.e., police, local administrators). Issues of power imbalance were also raised in the FGDs in relation to negotiating condom use with partners. For instance, girls in an FGD in Bujumbura said they wanted a program to address girls' weakness ("*faiblesses des filles*") in negotiating condom use with

partners “*to not underestimate yourself, to develop leadership*”. Gender and power are also intrinsically linked. Thus, any efforts to shift normative acceptance of coercive and exploitative transactional sex for AGYW will need to address the underlying gender and power imbalances that they face and in so doing to involve individuals in the community who hold that power, such as the local committees, leaders and teachers cited in our FGDs. Community engagement has also been identified as a high-impact practice for social and behavior change in family planning by a technical advisory group of international experts [42].

One innovative approach that has been taken to engaging communities, inclusive of local leaders, to address social norms, attitudes, and behaviors that perpetuate women and girls’ low status is exemplified by the Change Starts at Home intervention [43]. The Change Starts at Home intervention is a multicomponent social and behavior change communication (SBCC) strategy that uses media (radio and SMS) and community mobilization to prevent violence against women and girls (VAWG) in Nepal. Centered around an innovative radio and weekly listener group meetings, the intervention engages actors across multiple domains of influence, such as **family members and community leaders**, in addition to the primary target audience of married reproductive age women and their husbands. As a SBCC strategy, the intervention approaches VAWG prevention through three key approaches: advocacy, social mobilization, and behavior change communication. The behavior change communication component is a 9-month, weekly radio drama with listener engagement through interactive voice response and SMS, to which both the intervention and control conditions are exposed. The intervention communities are further engaged in radio Listening and Discussion Groups, through which the male and female participants meet to critically reflect on the content of the radio episode through a curriculum-based process of guided discussion, in-group, and home-based activities. Listening and Discussion Groups serve as venues for life skills building and act as a platform through which community outreach activities are planned and executed, alongside **local leaders** who receive training and support to act as advocates in the community for more equitable social norms.

The Stepping Stones program is another well-known program that seeks to address issues of gender and power in order to shift social norms around sexual and intimate partner violence [44]. Stepping Stones is a social norm change training package designed to be delivered via peer-led groups that addresses critical communication and relationship issues, including age-disparate transactional sex. The Stepping Stones intervention package has been implemented in over 65 countries including Burundi, and uses youth-friendly, mutually respectful, human rights lens to address issues of power and gender norms transformation. Both interventions provide frameworks to initiate broader discussion in the community about the gender and power imbalances that underlie sexual risk for AGYW and that were raised in the FGDs in this study.

Idea #4: Engage religious leaders as champions for FP

We found evidence that a new social norm around having smaller family sizes is in emergence (social norm #7). It is well-documented that as fertility rates fall this frees up adolescent girls to stay in school longer and become more productive members of the economy [45]. Given that this norm is in its nascency, we suggest that efforts to bolster this norm would have substantial benefits not only for the AGYW themselves but also within their larger communities and throughout the Burundi economy as a whole.

In our FGDs, religious leaders were often mentioned as key influencers of FP use, religious teachings on contraception and family size influenced the normative environment and religious institutions seemed to play a central role in communities. While it seemed that many religious teachings were still seen as being in opposition to use of contraceptives and FP, there was some description that religious institutions were promoting positive norms around sustainable family sizes, becoming more open to the benefits of FP, and providing information on condoms.

Based on these findings, and the fact that most people in Burundi are affiliated with and regularly attend religious services, we suggest that **churches, mosques, and religious leaders** will be critical and powerful collaborators to enlist in the transformation of social norms pertaining to RH. The Masculinité, Famille et Foi (MFF) intervention aimed to transform the underlying social norms that impede youth from accessing FP and RH care by working with Protestant faith communities in Kinshasa. The MFF intervention was designed to promote positive masculinities and gender equality, reduce gender-based and intimate partner violence and increase FP use [46].

MFF uses a process of participatory scriptural reflection and dialogue with faith leaders, faith leader workshops, gender champion training and support activities with congregation members, community dialogue sessions with couples, community mobilization, and group discussions. MFF is based on the idea that religious leaders can reduce the community's social acceptance of GBV and other gender inequalities and help congregants to understand that FP does not go against their faith and that these efforts would, in turn, create normative environments that are more supportive of women and men's access to and use of modern FP. By working with congregations, MFF attempts to shift norms by rooting the intervention within the community's own values, creating new norms of positive masculinity and couple relationships, and creating safe spaces for dialogue and critical reflection.

Given that participants mentioned a belief that churches are more amenable to use of natural FP methods, one idea to potentially include in any intervention trying to shift social perceptions of FP use might be to incorporate information about a natural FP method such as CycleBeads® developed by IRH [47]. CycleBeads® are a color-coded string of beads that help to track the days of the menstrual cycle and to show days of greatest probability of conception. The CycleBeads® intervention is also available as an app for phone or internet use and is currently being tested as an SMS (text messaging) service.

Engaging religious leaders and faith communities as important stakeholders in community-level social and behavior change initiatives is becoming an increasingly popular approach and other effective faith-based intervention models exist [48, 49]. Whatever the approach deemed most suitable to best engage them, it seems clear, in highly religious settings such as Burundi, that religious leaders, churches, mosques and faith communities will be critical allies in normative change efforts. They can not only dispel myths around contraceptive use but also be effective advocates for promoting positive new norms for masculinity and gender interactions and use of family planning methods and RH care.

Idea #5: Explore underlying drivers of health workers' bias

Overall, we found that it is not normative for AGYW to use contraception (social norm #8). Although we heard that contraceptives are technically available from local health workers, we also were told

that many girls feel uncomfortable with seeking contraceptive methods and that some health workers withhold information or care from unmarried AGYW and advise them to abstain from sex. This withholding of information by health care workers is potentially not surprising given that they are also subject to the normative environment in their communities (social norms #1 and #4) and thus are likely to hold biases or values that enforce the prevailing social norms.

Importantly, several health worker participants talked about their obligation to provide care to anyone who is seeking them. Capitalizing on providers' sense of obligation and duty may be a viable entry point in these provinces in Burundi to engage health workers to create a more supportive normative environment for provision of comprehensive FP/RH counseling and care to unmarried AGYW.

One intervention which explores the underlying drivers of **health workers'** own biases is the Beyond Bias project [50, 51]. The project started by identifying key underlying drivers of provider bias toward adolescent RH and then convened health providers, youth, and mothers-in-law in Burkina Faso, Pakistan, and Tanzania to co-create a behavior change strategy intervention, grounded in an accurate assessment of social norms. The intervention emphasized reduction of provider bias by creating positive new norms in delivery of care and safe spaces for critical reflection among **providers**. Specifically, it included three components: 1) story-driven events with providers to allow them to identify and recognize their own biases and train them on unbiased care; 2) a professional network of providers through a multiweek program of texts and videos over WhatsApp; and 3) report cards to provide positive reinforcement for progress and actionable recommendations with data to promote improvements. A randomized control trial is being planned for late 2020 to assess changes in provider bias, contraceptive use, and care.

Notably, a recent study on young people's (age 10-24) use of RH care in Burundi found that having youth-friendly components [52] was positively associated with young people's use of RH care. We consider unbiased, non-judgmental provider interactions to be a key component of youth-friendly care. We further suggest that combining these type of bias exploration activities with other proven effective intervention strategies, such as creating a youth-friendly care environment [53], is likely to be a powerful approach for shifting norms within healthcare settings and the larger communities in which they are situated.

Concluding Remarks

As stated in the Passages project snapshot, *"Enabling young women and men to live gender-equitable lives free of violence, coerced sex, and unintended pregnancy is a critical global challenge."* This challenge has recently been heightened by and taken on new urgency with the spread of COVID-19. The pandemic and related economic distress and migration are currently having notable influences on gender role expectations, GBV and family planning use in LMICs [54]. The findings and ideas laid out in this report contribute to the capacity of the Burundian government and NGOs to rise to this challenge and simultaneously to add to the evidence base needed to strengthen normative environments that support the RH and well-being of adolescents in Burundi and globally.

Given the large percentage of the Burundian population that are adolescents, investing in normative-focused RH health interventions to improve the well-being of adolescent girls will pay back a

substantial return on investment in terms of the girls' lives bettered and their improved ability to contribute to the country's economy and society. In turn, these benefits to AGYW will help to support Burundi in achieving the goals of its National Development Plan 2018-2027 and contributing to the Sustainable Development Goals (SDGs) and African Union Agenda 2063 [1].

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APPENDICES

Appendix A: List of members of study team

Appendix B : List of members of technical and steering committees

Appendix C : Focus group discussion guides for adolescents and key influencers

Appendix D : Illustrative example of problem tree from our study

Appendix A: List of members of study team

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Dr. Marie Claire Ryanguyenabi
Dr. Amini Hassan, DSNIS
Dr. Prosper Niyongabo, INSP
Marie Goreth Benimana, MSPLS
Emerencienne Tabu, DPSHA

Technical committee :

Dr. Jean Claude Bizimana, MSPLS
Dr. Ananie Ndacayisaba, PNSR
Olivier Gahungere, PNSR
Dr. Diomedé Ndayisenga, DPPS
Sadique Niyonkuru, PNSR
Jean Bosco Nzobonimpa, PNSR
Dr Eric Nzeyimana, ShareNet
Dr Jean Marie Ntibazomumpa, DSNIS
Rémy Nimubona, INSP
Pierre Claver Kayiro, ISTEEBU
Bienvenue Muhimpundu, MSPLS

Appendix C: Focus group discussion guides for adolescent and key influencers

Guide de discussion des focus groupes avec les adolescentes

Nagira ndabashimire kuba mwemeye kuza muri kino cigwa. Imbere ya vyose, nagomba dufate umunuta umwe twidondorane. Ndabaza umwe umwe uko mwicaye mwese agende atubwira igihe mumaze muba ngaha mu kibano n'ico mwifuza gukora aha mu kibano iwanyu.

Merci de votre participation à cette étude. Tout d'abord, prenons une minute pour faire connaissance. J'aimerais faire le tour de la table et que chacun de vous nous dise depuis combien de temps vous vivez dans cette communauté et ce que vous préférez faire dans votre communauté?

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Très bien, maintenant que nous nous connaissons un peu, je vais vous poser quelques questions sur la situation et le comportement d'autres filles comme vous dans votre communauté.

[Ajouté ici: Orientation aux normes sociales]

En particulier, nous sommes intéressés à parler aujourd'hui et à découvrir les normes sociales ici au Burundi. Par normes sociales, nous faisons référence à des règles de comportement non écrites. Pouvez-vous penser à certaines normes sociales ici au Burundi? Qu'en est-il de... [Certains mots ou sujets que l'on ne devrait pas ou ne devrait pas dire à différents endroits, certains vêtements qui devraient ou ne devraient pas être portés par des personnes d'âges et de genres différents?] Comment les gens se saluent ici avec trois baisers? Ou qu'en est-il des gens qui disent quand quelqu'un étrenue? Ou qu'en est-il de l'utilisation de nos téléphones portables?

Certaines de ces choses que nous faisons parce que nous voyons d'autres personnes les utiliser comme utiliser un téléphone portable ou se serrer la main lors de l'accueil. Et puis il y a d'autres normes sociales que nous suivons parce que nous savons que si nous les appliquons, nous recevrons des éloges ou des récompenses. Pouvez-vous penser à une norme sociale comme celle-ci?

[Exemples: une fille du bon âge qui se marie est félicitée, une femme mariée ayant un bébé est félicitée, une femme qui garde sa maison propre est félicitée]

Et il y a des normes sociales que nous savons que si nous ne les faisons pas, les gens pourraient faire des commentaires à notre sujet et / ou nous pourrions être punis. Pouvez-vous penser à quelques exemples de ce type de norme sociale?

Super maintenant que nous sommes orientés vers les normes sociales. Nous sommes intéressés à réfléchir aux normes sociales qui affectent les adolescentes comme vous et en particulier qui affectent les comportements de santé sexuelle et reproductive des filles. Nous souhaitons également savoir s'il existe des différences dans les normes sociales (ou les attentes qui affectent les filles à différents âges et dans différentes régions du Burundi... il y a peut-être des différences entre les zones urbaines et rurales, des différences selon l'âge, des différences entre les attentes communauté en général vs au foyer vs entre amis.

Certaines de ces questions peuvent vous rendre mal à l'aise. N'oubliez pas que nous ne vous demandons pas de partager vos expériences personnelles. Nous aimerions plutôt que vous parliez de la situation en général pour les filles de votre âge dans votre communauté. Merci de ne pas partager d'informations personnelles vous concernant. Cela a-t-il du sens? Avez-vous des questions?

Domaine A: Ubutinyanka n'isuku bijanye

Menstruations/Gestion de l'hygiène menstruelle

- 1. Mwibaza ko abigeme b'aho muherereye batangura kuja mu butinyanka bamaze imyaka ingahe ?**

A quel âge pensez-vous que la plupart des filles de votre communauté commencent à avoir leurs règles ? (Norme comportementale descriptive)

- 2. Iyo abigeme bo mu kibano batanguye kuja mu butinyanka, mwotubwira uko baca bifata? Nk'akarorero: abigeme bo mu kibano canyu bakoresha iki mu kugira isuku ry'ubutinyanka? Iyo bakoresheje babita hehe? Iyo ubutinyanka butuma baribwa, baca bavyifatamwo gute?**

Quand les filles de votre communauté commencent à avoir leurs règles, pouvez-vous décrire leur comportement typique ? Par exemple : quel type de matériel utilisent les filles de votre entourage pour gérer les menstruations ? Où est-il jeté après usage ? Et si les règles sont douloureuses, quelle est la conduite tenue par les filles de votre entourage ? (Norme comportementale descriptive)

- 3. N'izihe mpinduka zibonekeza ku bigeme b'aho mubaye bamaza gutangura kuja mu butinyanka ?**

Quels changements observe-t-on chez une fille de votre communauté qui commence à avoir les règles? (Conséquences sociales) Les gens de la communauté ou de son domicile la traitent-ils différemment une fois qu'elle a ses règles?

Informateurs clés/Personnes influentes en matière de menstruation et de gestion de l'hygiène menstruelle (Influenceurs clés)

- 1. Ni nde abigeme b'aho mubaye bitura iyo bakeneye inyigishozerekeye ibibashikira canke ico bokora iyo bari mu butinyanka ?Amavuriro? Abaremeshakiyago? Abavyeyi/Aberezi? Abandi bo mu muryango? Abigisha? Abagenzi?**

A qui les filles de votre communauté s'adressent-elles pour avoir des informations sur ce à quoi s'attendre et quoi faire en cas de menstruations ? Les formations sanitaires (FOSA) locales ? Les agents de santé communautaires (ASCs) ? Les parents/tuteurs ? Autres membres de la famille ? Les enseignants ? Les amies ? (Norme comportementale descriptive)

- 2. Mu bisanzwe, abigeme bahabwa na nde impanuro zerekeye ubutinyanka n'isuku bijanye?**

De qui les filles obtiennent-elles le conseil concernant la menstruation et l'hygiène menstruelle? (Norme comportementale descriptive)

- 3. Nimba abigeme bamaze gutangura kuja mu butinyanka baca bahindura inyifato, ni nde ajejwe kuraba ko iyo nyifato yahindutse?**

Si les filles sont censées changer de comportements une fois qu'elles commencent à avoir leurs règles, qui dans la communauté s'assure de ce changement?

Domaine B: Imico ituma abigeme bageramirwa bifatiye ku gitsina?

Les normes sociales qui influencent le risque sexuel chez les filles

- 4. Tuganire ku vyerekeye inyifato iranga abigeme b'aho mubaye.**

Mbega birigaragaza canke hari akarorero mwotanga kerekeye ? Mwame mwibuka ko tudashaka ko umuntu avuga ibijanye n'ubuzima bwiwe ariko twifuza ko mutubwira ibiba muri rusangi.

Parlons de ce qu'est un comportement sexuel typique pour les filles de votre communauté. (Norme comportementale descriptive) N'oubliez pas que nous ne vous demandons pas de partager vos expériences personnelles. Nous aimerions plutôt que vous parliez de la situation en général pour les filles de votre âge dans votre communauté.

- a. Mubisanzwe abigeme batangura kurangur'imibonano mpuzabitsina bafise imyaka ingahe?**

Typiquement, à quel âge les filles font-elles leur premier rapport sexuel

- b. Birasanzwe ko abigeme barangur'imibonano mpuzabitsina imbere yo kwubaka izabo ?**

Est-ce que les filles typiquement font des rapports sexuels avant le mariage ?

- c. Birasanzwe ko abigeme bagendana kandi baranguran'imibonano mpuzabitsina n'uwurenga umwe?**

Est-ce que les filles typiquement ont plus d'un partenaire sexuel?

- d. Mbega abigeme barangur'imibonano mpuzabitsina kugira bahabwe ibintu canke amafaranga?**

Est-ce que les filles font des rapports sexuels en échange de cadeaux ou d'argent ?

- e. Ko abigeme bakoresha udukingirizo mu kurangur'imibonano mpuzabitsina ?**

Est-ce que les filles typiquement utilisent des préservatifs?

- f. Ko abigeme barangur'imibonano mpuzabitsina iyo banyoye inzoga ziborera ?**

Est-ce que les filles typiquement font des rapports sexuels après avoir bu des boissons alcoolisées?

- 5. (Ubu ko tumaza kubona inyifato ikunze kuboneka, reka tuganire ku vyerekeye inyifato ibereye ku bigeme b'aho muherereye mubijanye n'imibonano mpuzabitsina.**

Maintenant que nous avons décrit le comportement sexuel typique, parlons de ce qu'est un comportement sexuel acceptable pour les filles de votre communauté (Normes subjectives)

- a. Gerageza gutahura cane kubijanye n'ivyo vyiyumviro bimaze kuvugwa hamwe n'ibindi vyiyumviro vyose abari mu kiganiro bashikirije atawubibajije)**

Approfondissez les sujets ci-dessus et discutez des autres sujets que les participants ont évoqués spontanément.

- 6. N'ibiki bishobora gushika canke n'iyihe nyitafo ababanyi bagira ku mwigeme :**

Qu'est-ce qui arrive ou quelle est la réaction de la communauté envers des filles qui: (conséquences sociales)

- a. Yagize imibonano mpuzabitsina atarubaka urwiwe ?**

Font des rapports sexuels avant le mariage?

- b. Aranguran'imibonano mpuzabitsina n'abantu benshi (barenga umwe) ?**

Ont plus d'un partenaire sexuel ?

- c. Bakora imibonano mpuzabitsina kugira bahabwe ibintu canke amafaranga? Abafise ba ikimanjema?**

Ont des rapports sexuels en échange de cadeaux ou d'argent ? Ont un papa-gâteau?

- d. Bakor'imibonano mpuzabitsina iyo banyoye inzoga?**

Font des rapports sexuels après avoir bu de l'alcool?

Informateurs clés/Personnes influentes en matière de comportements sexuels de filles (Influenceurs clés)

7. Abigeme b'aho muherereye baganira na nde ivyerekeye imibonano mpuzabitsina ?
A qui les filles de votre communauté parlent-elles au sujet des rapports sexuels?

8. Abigeme b'aho muherereye bakura he impanuro zerekeye ivy'imibonano mpuzabitsina? Canke kubo bokorana imibonano mpuzabitsina ?
De qui les filles obtiennent-elles des conseils en rapport avec le sexe? En rapport avec les partenaires sexuels?

9. Aho muherereye, ni ba nde bagira uruhara mu ngingo umwigeme afata mu vyerekeye imibonano mpuzabitsina ? Igitigiri c'abo bokorana imibonano mpuzabitsina n'imyaka boba bafise, canke ko yokora imibonano mpuzabitsina kugir'aronke ibintu canke amafaranga ?
Dans cette communauté, qui influence les décisions d'une fille en matière de sexe? Combien de partenaires avoir, âge des partenaires sexuels ou échange de rapports sexuels contre des cadeaux/argent?

Domaine C: Amabi afatiye ku gitsina

Violence sexuelle

Ariko ntimwibagire ko tutabasaba kutubwira ubuzima bwanyu ariko dushaka ko muvuga ibintu muri rusangi uko biri ku bakobwa bo mu runganwe aha mu kibano. Ndabasaba ko mutavuga ibibaraba kugiti canyu. Kuko hari abo iki kibazo cobabaza.
N'oubliez pas que nous ne vous demandons pas de partager vos expériences personnelles. Nous aimerions plutôt que vous parliez de la situation en général pour les filles de votre âge dans votre communauté. Merci de ne pas partager d'informations personnelles vous concernant. Certains aspects de cette question peuvent être sensibles.

13A. Dans votre communauté, avez-vous entendu parler de filles battues ou frappées par leurs partenaires sexuels? Quelle est la fréquence de ce comportement?

10. Aho muherereye, mwoba murumva havugwa abigeme baremerwa n'abo bagendana canke abandi bantu kugira bakore imibonano mpuzabitsina ? Iyo nyifato iri ku rugero rungana iki ?

Dans votre communauté, avez-vous entendu parler de filles qui subissent la pression de leurs partenaires ou d'autres pour faire des rapports sexuels? Quelle est la fréquence de ce comportement? (Normes comportementales descriptives)

11. Aho muherereye, mwoba murumva havugwa abigeme bakora imibonano mpuzabitsina ku kagobero k'abo bagendana canke abandi ? Iyo nyifato iri ku rugero rungana iki ?

Dans votre communauté, avez-vous entendu parler de filles forcées à faire des rapports sexuels par leurs partenaires ou par d'autres? Quelle est la fréquence de ce comportement? (Normes comportementales descriptives)

12. Aho muherereye, mwoba murumva abigeme bagobererwa kwubaka izabo bataragera? Iyo nyifato iri ku rugero rungana iki ?

Dans votre communauté, avez-vous entendu parler de filles forcées à faire des mariages précoces? Quelle est la fréquence de ce comportement?(Normes comportementales descriptives)

13. Abantu b'aho mubaye bakora iki iyo bumvise uwakorewe amabi afatiye ku gitsina ?

(Conséquences sociales)

16A. Dans votre communauté, qu'arrive-t-il à une fille si elle dit non à quelqu'un qui la pousse à avoir des relations sexuelles?

Sondes possibles:

Qu'arrive-t-il à la fille? Et qu'advient-il de l'homme qui a commis l'acte?

Y a-t-il des situations où elle peut dire non et quand elle ne peut pas dire non? Pouvez-vous décrire ce qui se passerait dans différentes situations?

16B. Dans votre communauté, si une fille est victime de rapports sexuels forcés, peut-elle en parler aux autres?

Sondes possibles:

À qui peut-elle parler? [ses amis, avec leurs parents, avec les dirigeants de l'église]; peut-elle le signaler à la police? Que se passera-t-il si elle le fait?

Que va-t-il lui arriver quand les autres le découvriront? Connaissez-vous des situations comme celle-ci? Pouvez-vous décrire ce qui s'est passé?

16B. Quelle est la conduite des gens de votre communauté face à la violence sexuelle quand elle se produit?

Dans votre communauté, est-il acceptable que des personnes de la communauté parlent de violence sexuelle?

Sondes possibles:

La police en parlent-ils? Les chefs d'église en parlent-ils? Pouvez-vous m'en dire plus à ce sujet?

Qu'est-ce-qu'ils disent?

En parle-t-on à l'école? Pouvez-vous m'en dire plus à ce sujet? Qu'est-ce-qu'ils disent?

En parle-t-on à la maison? Pouvez-vous m'en dire plus à ce sujet? Qu'est-ce-qu'ils disent?

Informateurs clés/Personnes influentes en matière de Violence sexuelle (Influenceurs clés)

14. Mbega abigeme b'aho mubaye bokwitura nde mugihe bakorewe amabi afatiye ku gitsina canke bafashwe ku nguvu ?

Vers qui une fille de cette communauté se confierait-elle pour parler d'un incident de violence sexuelle ou de viol?

15. N'uyuhe wundi muntu mu kibano yitaho ivyerekeye amabi afatiye ku gitsina canke agerageza gufasha abayakorewe?

Qui d'autre dans cette communauté s'inquiète de la violence sexuelle ou essaie d'aider les victimes de violence sexuelle?

16. N'uyuhe wundi muntu mu kibano afise uruhara rwo gukinga canke kurwanya amabi afatiye ku gitsina?

Qui d'autre dans cette communauté serait influent dans la prévention ou la réponse à la violence sexuelle?

Domaine D: Kwipfuzza kurondoka hamwe n'imico yerekeye ukurondoka ku rugero

Désirs de fécondité et normes relatives à la planification familiale

17. Mbeg'aho mubaye, umuryango w'akarorero n'uwufise abana bangahe?

Dans votre communauté, une famille que vous considérez comme modèle a combien d'enfants? (Normes comportementales descriptives)

18. Mbeg'aho mubaye, abantu biyumvira iki ku vyerekeye gukoresha uburyo bwo kurondoka ku rugero ?

Dans votre communauté, qu'est-ce que les gens pensent de l'utilisation des méthodes de planification familiale? (Conséquences sociales)

19. Mwibaza ko abigeme b'aho mubaye mungana basanzwe bakoresha uburyo bwo kwikingira imbanyi batipfuzza?

Pensez-vous que les filles de votre âge dans votre communauté utilisent habituellement des méthodes contraceptives? (Normes comportementales descriptives) Pensez-vous que les filles envisagent d'utiliser des méthodes contraceptives à l'avenir?

Sonde possible: Et si oui, dans quel but?

20. Aho mubaye, abantu bifata gute iyo babonye abigeme bariko barondera uburyo bwo gukinga imbanyi? Abigeme bahura n'izihe ntambanyi mugihe bifuje kuronka uburyo bwo gukinga imbanyi?

Dans votre communauté, comment les gens réagissent-ils vis-à-vis des filles quand elles essaient d'obtenir une méthode contraceptive? Quels sont les défis auxquels les filles font face dans ce domaine? (Conséquences sociales)

Informateurs clés/Personnes influentes en matière de désirs de fécondité et de planification familiale (Influenceurs clés)

21. Abigeme b'aho mubaye baganira na ba nde ivyerekeye kuvyara ku rugero ?

Avec qui les filles de cette communauté discutent-elles de la planification familiale ?

22. Iyo bakeneye impanuro zerekeye uburyo bwo gukinga imbanyi ho bitura ba nde?

À qui d'autre demandent-elles des conseils sur l'utilisation des méthodes de planification familiale?

23. Abandi bantu bashobora kubaha inyigisho zerekeye gukinga imbanyi ni ba nde?

De qui d'autre obtiennent-elles des informations sur la planification familiale?

Domaine E: Ubusumbane bw'ibisata vy'imico yaganiriweko

Hiérarchisation des domaines relatifs aux normes sociales ayant fait objet de discussion

24. Kubwanyu, n'iyihe ngorane isumvya izindi mu kugira ingaruka ku bigeme b'aho mubaye ? (uturorero: isuku rijanye n'ubutinyanka, amabi afatiye ku bitsina, inyifato zifatiye ku gitsina canke gukinga imbanyi)

D'après vous, lequel de ces problèmes (par ex., gestion de l'hygiène menstruelle, violence sexuelle, comportements sexuels ou contraception) a le plus d'impact sur les filles de cette communauté? Pourquoi pensez-vous que c'est le plus important?

Guide de discussion des focus groupes avec les influenceurs

[Ku bagirisha ikiganiro : ibi bibazo ntibazwa abantu bose bari mu mirwi ifise uruhara canke y'isungwa mu nyifato y'urwaruka mu bisata vyose. Ibibazo bijanye n'umurwi wose bizobazwa hisunzwe umurwi uzoba watowe.]

[Note aux agents de collecte de données: Vous ne poserez pas toutes les questions de groupes d'influence sur tous ces domaines. Les domaines d'investigation spécifiques à chaque groupe de discussion seront déterminés une fois les groupes d'influence identifiés.]

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Comment les gens se saluent ici avec trois baisers? Ou qu'en est-il des gens qui disent quand quelqu'un éternue? Ou qu'en est-il de l'utilisation de nos téléphones portables?

Certaines de ces choses que nous faisons parce que nous voyons d'autres personnes les utiliser comme utiliser un téléphone portable ou se serrer la main lors de l'accueil. Et puis il y a d'autres normes sociales que nous suivons parce que nous savons que si nous les appliquons, nous recevrons des éloges ou des récompenses. Pouvez-vous penser à une norme sociale comme celle-ci?

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Et il y a des normes sociales que nous savons que si nous ne les faisons pas, les gens pourraient faire des commentaires à notre sujet et / ou nous pourrions être punis. Pouvez-vous penser à quelques exemples de ce type de norme sociale?

Super, maintenant que nous sommes orientés vers les normes sociales. Nous sommes intéressés à réfléchir aux normes sociales qui affectent les adolescentes et en particulier qui affectent les comportements de santé sexuelle et reproductive des filles. Nous souhaitons également savoir s'il existe des différences dans les normes sociales (ou les attentes) qui affectent les filles à différents âges et dans différentes régions du Burundi... il y a peut-être des différences entre les zones urbaines et rurales, des différences selon l'âge, des différences entre les attentes communauté en général vs au foyer vs entre amis.

Certaines de ces questions peuvent vous rendre mal à l'aise. N'oubliez pas que nous ne vous demandons pas de partager vos expériences personnelles. Nous aimerions plutôt que vous parliez de la situation en général pour les filles de votre âge dans votre communauté. Merci de ne pas partager d'informations personnelles vous concernant. Cela a-t-il du sens? Avez-vous des questions?

Domaine A: Ubutinyanka n'isuku bijanye

Menstruations/Gestion de l'hygiène menstruelle

1. Mwibaza ko abigeme b'aho muherereye batangura kuja mu butinyanka bamaze imyaka ingahe ?

A quel âge pensez-vous que la plupart des filles de votre communauté commencent à avoir leurs règles ? (Normes comportementales descriptives)

2. N'izihe mpinduka zibonekeza ku bigeme b'aho mubaye bamaza gutangura kuja mu butinyanka ?

Quels changements observe-t-on chez une fille de votre communauté qui commence à avoir les règles? (Conséquences sociales) Les gens de la communauté ou de son domicile la traitent-ils différemment une fois qu'elle a ses règles?

Domaine B: Imico ituma abigeme bageramirwa bifatiye ku gitsina?

Les normes sociales qui influent sur le risque sexuel chez les filles

3. Tuganire ku vyerekeye inyifato iranga abigeme b'aho mubaye. Mbega birigaragaza canke hari akarorero mwotanga kerekeye ?

Parlons de ce qu'est un comportement sexuel typique pour les filles de votre communauté. (Normes Comportementales Descriptives)

a. Abigeme batangura kurangur'imibonano mpuzabitsina bafise imyaka ingahe?

Quel âge habituel auquel les filles font leur premier rapport sexuel ?

b. Vyoba bimenyerewe ko abigeme barangur'imibonano mpuzabitsina imbere yo kwubaka izabo ?

Est-ce habituel que les filles fassent des rapports sexuels avant la mariage ?

c. Vyoba bimenyerewe ko abigeme bagendana baranguran'imibonano mpuzabitsina n'uwurenga umwe?

Est-ce habituel pour les filles d'avoir plus d'un partenaire sexuel?

d. Vyoba bimenyerewe ko abigeme barangur'imibonano mpuzabitsina kugira bahabwe ibintu canke amafaranga?

Est-ce habituel pour les filles de faire des rapports sexuels en échange de cadeaux ou d'argent ?

e. Vyoba bimenyerewe ko abigeme bakoresha udukingirizo mu kurangur'imibonano mpuzabitsina ?

Est-ce habituel pour les filles d'utiliser des préservatifs lors des rapports sexuels?

f. Vyoba bimenyerewe ko abigeme barangur'imibonano mpuzabitsina iyo banyoye inzoga ziborera ?

Est-ce habituel pour les filles de faire des rapports sexuels après avoir bu des boissons alcoolisées ?

4. Ko tumaze kubona inyifato ikunze kuboneka ku bigeme b'aho muherereye, reka tuganire ku vyerekeye inyifato ibereye ku bigeme. N'ibiki bishobora gushika canke n'iyihe nyitafo ababanyi bagira ku bigeme :

Maintenant que nous avons décrit le comportement sexuel habituel des filles de votre communauté, parlons des comportements sexuels acceptables pour les filles (normes subjectives). Dans votre communauté, qu'est-ce qui arrive ou quelle est la réaction de la communauté envers des filles qui: (conséquences sociales)

a. Barangur'imibonano mpuzabitsina imbere yo kwubaka izabo ?

Font des rapports sexuels avant le mariage?

b. Baranguran'imibonano mpuzabitsina n'abantu benshi (barenga umwe) ?

Ont plus d'un partenaire sexuel?

c. Bakora imibonano mpuzabitsina kugira bahabwe ibintu canke amafaranga? Baronkeikimanjema?

Echangent des rapports sexuels contre des cadeaux ou de l'argent ou pour avoir un papa-gâteau?

d. Bakor'imibonano mpuzabitsina iyo banyoye inzoga?

Font des rapports sexuels après avoir bu des boissons alcoolisées?

Domaine C: Amabi afatiye ku gitsina ?

Violence Sexuelle

5A. Dans votre communauté, avez-vous entendu parler de filles battues ou frappées par leurs partenaires sexuels? Quelle est la fréquence de ce comportement?

5. Aho muherereye, mwoba murumva havugwa abigeme baremerwa n'abo bagendana canke abandi bantu kugira bakore imibonano mpuzabitsina?

Dans votre communauté, avez-vous entendu parler de filles qui subissent la pression de leurs partenaires ou d'autres pour faire des rapports sexuels?

a. Iyo nyifato iri ku rugero rungana iki?

Est-ce courant ou fréquent? (Normes comportementales descriptives)

6. Aho muherereye, mwoba murumva havugwa abigeme bakora imibonano mpuzabitsina ku kagobero k'abo bagendana canke abandi?

Dans votre communauté, avez-vous entendu parler de filles forcées à faire des rapports sexuels par leurs partenaires ou par d'autres personnes?

a. Iyo nyifato iri ku rugero rungana iki?

Est-ce courant ou fréquent? (Normes comportementales descriptives)

6A. Dans votre communauté, qu'arrive-t-il à une fille si elle dit non à quelqu'un qui la pousse à avoir des relations sexuelles?

Sondes possibles:

Qu'arrive-t-il à la fille? Et qu'advient-il de l'homme qui a commis l'acte?

Y a-t-il des situations où elle peut dire non et quand elle ne peut pas dire non? Pouvez-vous décrire ce qui se passerait dans différentes situations?

6B. Dans votre communauté, si une fille est victime de rapports sexuels forcés, peut-elle en parler aux autres?

Sondes possibles:

À qui peut-elle parler? [ses amis, avec leurs parents, avec les dirigeants de l'église]; peut-elle le signaler à la police? Que se passera-t-il si elle le fait?

Que va-t-il lui arriver quand les autres le découvriront? Connaissez-vous des situations comme celle-ci? Pouvez-vous décrire ce qui s'est passé?

7. Abantu b'aho mubaye bakora iki iyo bumvise uwakorewe amabi afatiye ki gitsina?

Que font les gens de votre communauté face à la violence sexuelle quand elle se produit?

(Conséquences sociales)

7A. Dans votre communauté, est-il acceptable que des personnes de la communauté parlent de violence sexuelle?

Sondes possibles:

La police en parlent-ils? Les chefs d'église en parlent-ils? Pouvez-vous m'en dire plus à ce sujet?

Qu'est-ce-qu'ils disent?

En parle-t-on à l'école? Pouvez-vous m'en dire plus à ce sujet? Qu'est-ce-qu'ils disent?

En parle-t-on à la maison? Pouvez-vous m'en dire plus à ce sujet? Qu'est-ce-qu'ils disent?

Domaine D: Ivyipfuzo vyo kurondoka hamwe n'umico yerekeye ukurondoka ku rugero

Désirs de fécondité et normes relatives à la planification familiale

8. Mbeg'aho mubaye, umuryango w'akarorero n'uwufise abana bangahe?

Combien d'enfants qu'une famille-type a dans votre communauté? (Normes comportementales descriptives)

9. Mbeg'aho mubaye, abantu biyumvira iki ku vyerekeye gukoresha uburyo bwo kurondoka ku rugero ?

Dans votre communauté, qu'est-ce que les gens pensent du recours aux méthodes de planification familiale? (Conséquences sociales)

Mwibaza ko abigeme b'aho mubaye boba bakoresha uburyo bwo kwikingira imbanyi batipfuza?

Pensez-vous que les filles de votre communauté utilisent habituellement des méthodes contraceptives? Pensez-vous que les filles envisagent d'utiliser des méthodes contraceptives à l'avenir?

Sonde possible: Et si oui, dans quel but?

10. Aho mubaye, abantu bifata gute iyo babonye abigeme bariko barondera uburyo bwo gukinga imbanyi?

Dans votre communauté, comment les gens réagissent-ils vis-à-vis des filles qui essaient d'obtenir des méthodes contraceptives?

a. Abigeme bahura n'izihe ntambanyi mu vyerekeye gushikira uburyo bwo gukinga imbanyi?

Quels sont les défis auxquels les filles font face pour obtenir des méthodes contraceptives ? (conséquences sociales)

Domaine E: Ubusumbane bw'ibisata vy'imico yaganiriweko

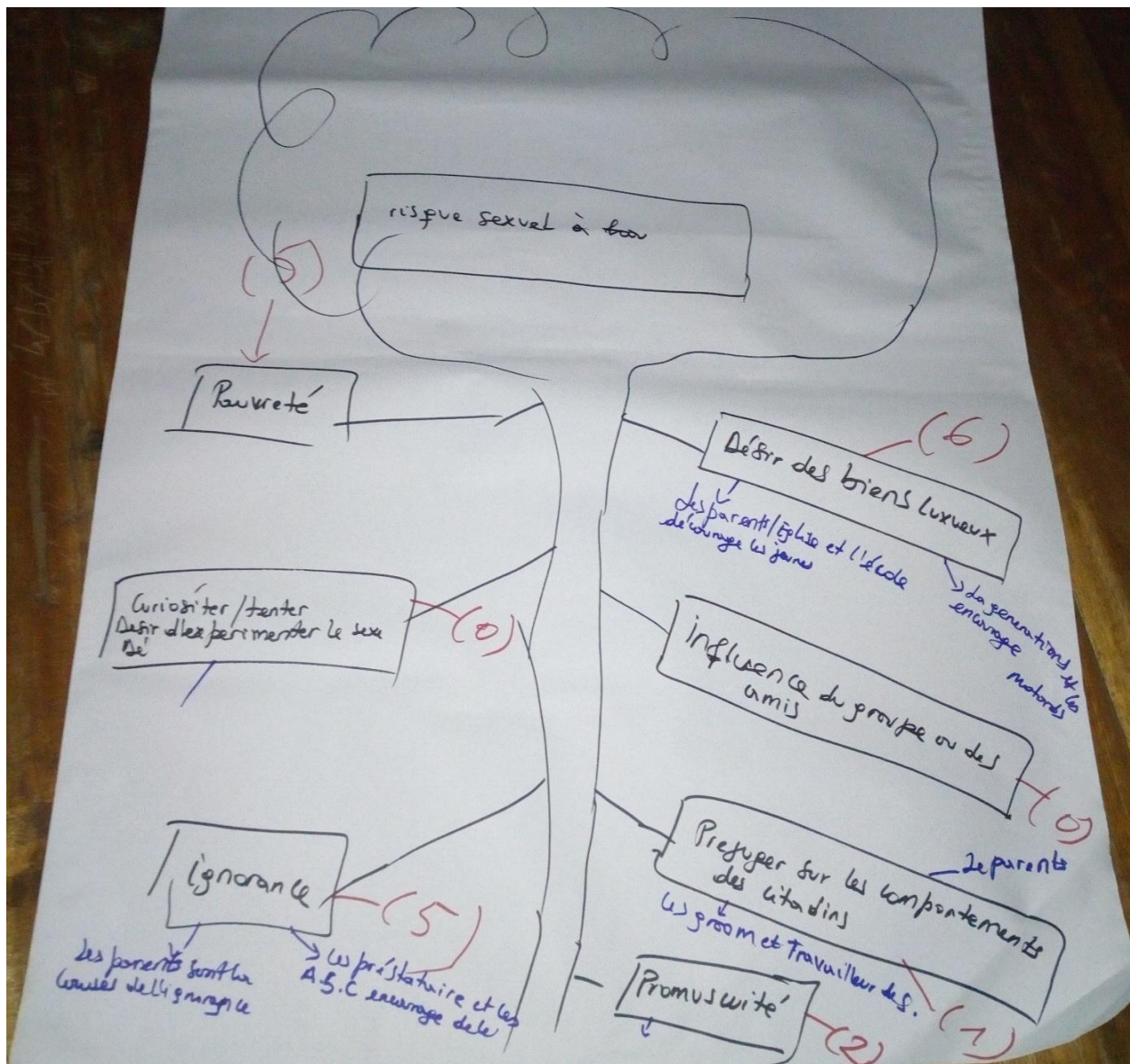
Hiérarchisation des domaines relatifs aux normes sociales ayant fait objet de discussion

25. Kubwanyu, n'iyihe ngorane isumvya izindi mu kugira ingaruka ku bigeme b'aho mubaye ? (uturorero: isuku rijanye n'ubutinyanka, amabi afatiye ku bitsina, inyifato zifatiye ku gitsina canke gukinga imbanyi)

D'après vous, lequel de ces problèmes (par ex., gestion de l'hygiène menstruelle, violence sexuelle, comportements sexuels ou contraception) a le plus d'impact sur les filles de cette communauté? Pourquoi pensez-vous que c'est le plus important?

Appendix D : Sample problem tree exercise

This is a photograph of the problem tree exercise done by an FGD with health providers in Muyinga:



Ubu naho, tugira dukore igikorwa co guhanahana ivyiyumviro.
Maintenant, nous allons faire un remue-méninges de groupe.

Igiti c'ingorane

Activité d'arbre à problèmes

- Tracez un grand arbre sur un morceau de papier (ou, idéalement, sur flipchart) comme dans l'exemple ci-contre. Si vous examinez plus d'un comportement d'intérêt, vous devrez dessiner un arbre pour chacun d'eux.** /Ni mucape igiti kinini ku rupapuro (vyiza mwokoresha flip chart) mukwirikije aka karorero mubona. Mugihe muriko mwiga inyifato, mucape igiti kimwe kimwe buri nyifato muriko muriga
- Ecrivez le (s) comportement (s) d'intérêt sur le tronc de l'arbre** /Ni mwandike inyifato iriko canke ziriko zirigwa
- Demandez aux participants d'indiquer ce qu'ils pensent être les raisons (ou les causes profondes) pour lesquelles les gens adoptent (ou pas) le(s) comportement(s) d'intérêt. Ecrivez chaque réponse sur une racine de l'arbre («la cause fondamentale»).** /Ni mubaze abaje mu kiganiro bavuge icyo/ivy bibaza bituma abatuntu bagira inyifato runaka (mu nyifato ziriko zirigwa). Andika inyishu ku mizi ya ca giti (nukuvuga imvo nyamukuru zituma abantu bagira inyifato runaka)



Illustrative Case Study: Example of Problem Tree Analysis for FP use for Newly Married Women from

- Cherchez des raisons supplémentaires en demandant aux participants comment, à leur avis, une cause fondamentale entraîne une autre jusqu'à ce que les participants n'aient plus de réponses.** / Rondera izindi mvo mu kubaza abari mu kiganiro ukuntu imvo nyamukuru ishobora kugira izindi mvo gushika aho abari mu kiganiro atazindi nyishu baba bagitanga
- Une fois que vous avez lancé les idées avec le groupe sur toutes les raisons possibles (causes fondamentales), demandez au groupe d'identifier les cinq principales raisons (plus ou moins selon les objectifs de votre projet) du ou des comportement(s) d'intérêt. Entourez ces raisons avec un stylo de couleur différente.** Mugihe mumaze gutanguza ikibazo kubijanye n'imvo zishoboka (canke impamvu nyamukuru), nimusabe abari mukiganiro gutoramwo imvo nyamukuru zitanu (bivanye n'intumbero z'umugambi wanyu) haba inyifato muriko muriga
 - Continuez à demander au groupe si et comment chacune des cinq principales raisons influence tous les groupes de la même manière ou si une cause fondamentale a un impact plus fort sur certaines personnes plutôt que sur d'autres.** Nimubandanye mubaza abari mu kiganiro niba izo mvo zitanu zatanze zikora co kimwe ku nyifato y'abantu n'ingene zikora kuri abo bantu canke n'iba imvo nyamukura ishobora gukora kubantu bamwe kuruta abandi.
 - Au fur et à mesure que des groupes spécifiques sont discutés, posez des questions sur qui récompense ou punit les personnes qui adoptent ou non le comportement d'intérêt.** Uko hari imigwi runaka ivuzwe, nimubaze ibibazo kubijanye n'uwushobora gushimira canke guhana abantu bagize canke batagize icyo nyifato iriko irigwa.

7. **Assurez-vous d'avoir quelqu'un qui prend notes pour enregistrer la discussion et, si possible, prendre des photos de votre arbre à problèmes à mesure qu'il évolue (voir l'étude de cas illustrative du projet Transforming Masculinities).** Mwitwararike ko hari umuntu ariko arafata amajwi y'ikiganiro kandi mu gihe bishoboka hafatwe amafato y'ico giti c'ingorane uko bagenda bacuzuzu (Murabire akarorera ku mugambi «Transforming Masculinities »).

Nongeye kubashimira ko mwatwitavye kugira tunganire. Har'ico mwoshobora kwongera ku vyo twaganiriye?

Merci beaucoup d'avoir participé à cette discussion aujourd'hui. Voudriez-vous ajouter quelque chose à propos de ce dont nous avons parlé aujourd'hui?