Improving Support for Delaying Early Childbearing Among Newly Married Adolescent Girls

Qualitative Evaluation of the CARE IMAGINE Project in Niger and Bangladesh

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To learn more about CARE's IMAGINE project and obtain reference materials please visit: https://www.care.org/our-work/health/adolescent-health/imagine/

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Background and Context

Each year around the world, almost 13 million girls under the age of 20 give birth, nearly 1 million of whom are younger than 15 (1). Child marriage is a strong indicator of early birth; 90% of adolescent pregnancies in the developing world are to girls who are already married; and married adolescents are more likely to experience frequent and early pregnancies than their unmarried peers (2, 3). Adolescent girls who undergo early marriage (often defined as prior to age 18) and subsequent rapid birth are more likely to experience a host of negative physical, mental and economic outcomes, including complications during pregnancy and delivery, higher rates of maternal mortality, and poor educational and economic outcomes for both themselves and their children (2-5).

A number of factors influence married adolescent girls' ability to delay early childbearing. Entrenched social norms around gender roles, rooted strongly in community and family contexts, equate a girl's value with her ability to procreate (5-7). Stigma associated with rumors of infertility also yield powerful influence over young couples' fertility choices, driving them to prove their fecundity through immediate birth (7, 8). Married adolescent girls also are less likely to engage in family planning (FP), due to a lack of knowledge of contraceptives and male-dominated partner dynamics that limit their individual ability to control the timing and frequency of pregnancy (5, 9, 10). Furthermore, both unmarried and married adolescents experience an inordinate number of obstacles to accessing reproductive services within the formal health system, including bias of providers, stigma around contraceptive use, and lack of physical or financial access to health facilities (11-14).

Adolescent sexual and reproductive health in Niger

Niger has among the poorest sexual and reproductive health (SRH) outcomes of any country in the world, with the highest fertility rate (7.6 children per woman) and a maternal mortality rate of 590 deaths per 100,000 births (15). Adolescent girls are at significant risk, with average age of first marriage at 15.7 and average age of first birth at 18.5; in fact, over 70% of adolescents in Niger are married by the age of 19 (15). Adolescent birth rates in Niger are a staggering 207 per 1,000 women ages 15-19; and high even among the youngest adolescents – 12.8% of girls have given birth before the age of 15 (16). Maternal mortality among adolescents accounts for 34% of all deaths in this group (15).

Overall, modern contraceptive prevalence among married women across the country is low, at only 12%. Young women have lower knowledge of contraceptive methods than older women (77.4% among ages 15-19, compared with 91% for ages 25-29), and considerably lower modern method use (5.6% among ages 15-19, compared with 16% among ages 25-29) (15). This results in 34.4% of maternal deaths occurring among adolescents ages 15-19 (1).

Adolescent SRH in Bangladesh

In Bangladesh, the legal minimum age for marriage is 18 for girls, but enforcement of this law is weak (17). The current median age at first marriage is 15.8, and 66% of Bangladeshi women report giving birth before age 18 (18). Patriarchal norms and social structures make it difficult for girls to refuse sex or use contraceptives, particularly in the context of marriage (19, 20). Young wives are less able than their older peers to negotiate family planning decisions with their husbands and extended family. This lack of agency leaves young brides unable to time and space their pregnancies in a way that can improve their health and well-being and that of their children and families (19, 21). Misconceptions about contraceptive methods, particularly as related to risk of infertility, discourage young women from using them to delay early pregnancy (19, 22). Because of these factors, the rate of adolescent pregnancy has declined only slightly over the past two decades. In 1993, adolescents made up 33% of all births or pregnancies, compared with 30.8% in 2014 (23).

Despite the seemingly bleak statistics in adolescent sexual and reproductive health, Bangladesh has experienced recent gains in economic development and advancement of women's rights. From 1991-1992 to 2010, the country reduced its poverty rate by nearly half (from 57% to 32%) (24). Progress in girls' education has resulted in near gender parity for primary school enrollment (25). And maternal

mortality has declined from 569 deaths per 100,000 births in 1990, to 196 deaths per 100,000 live births in 2015 (26). The disparity between advances in general health and economic indicators and stagnant adolescent pregnancy rates suggests a particularly complex set of factors preventing improvement in young girls' lives.

Support for adolescent SRH

CARE, with support from the Bill and Melinda Gates Foundation, designed the IMAGINE intervention *(Inspiring Married Adolescent Girls to Imagine New Empowered Futures)* to address the persistent issue of early birth among young married adolescents in Niger and Bangladesh. To better understand the social norms, individual and structural barriers and facilitators to married girls delaying first birth, CARE conducted a comprehensive formative evaluation. The results of this study informed a human-centered design process whereby CARE and its partners designed IMAGINE, a holistic intervention that builds girls' agency, tackles social and structural dynamics that perpetuate early pregnancy, and presents alternative economic opportunities for girls so that early motherhood is not their only option.

This qualitative evaluation examines if and how key participants and stakeholders in each community are experiencing change in attitudes and behaviors around delaying early adolescent childbirth stemming from the IMAGINE intervention.

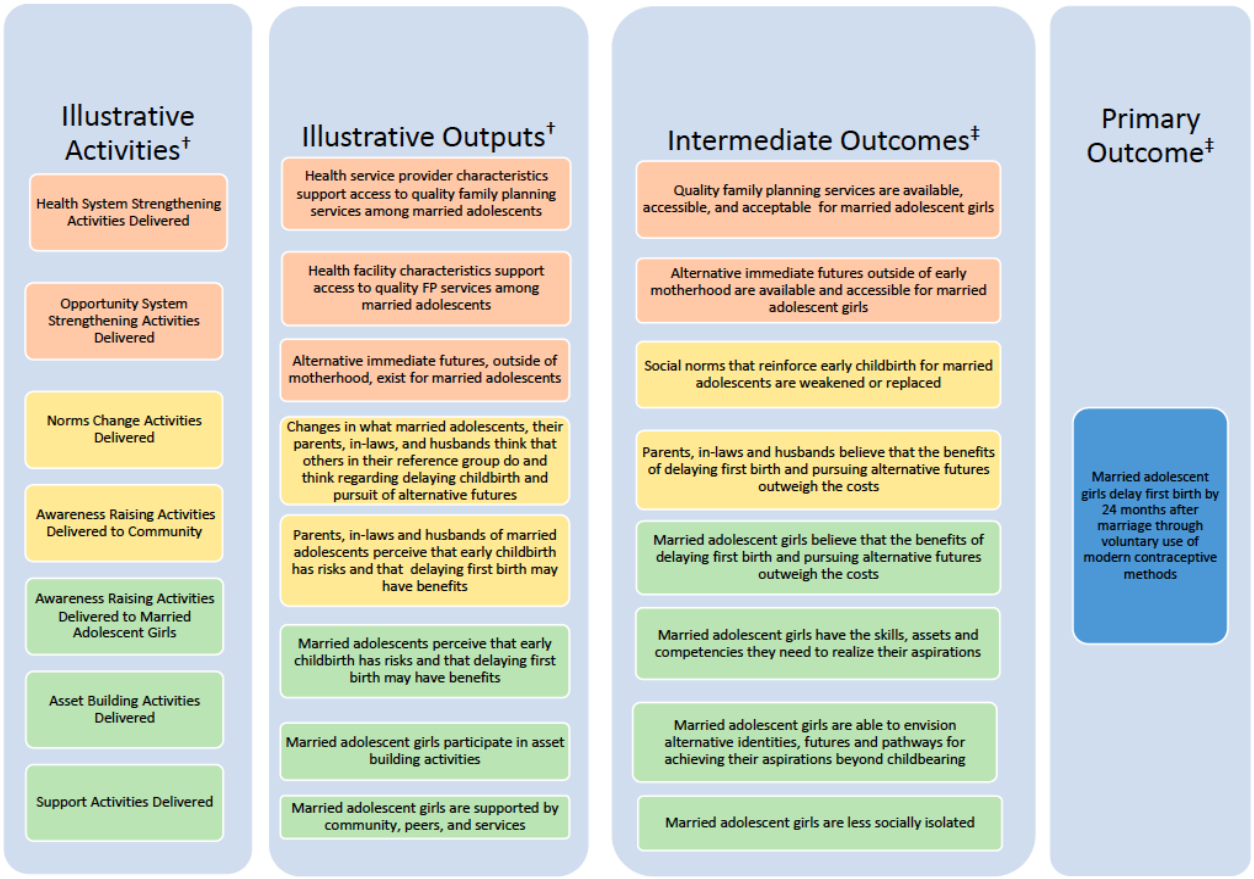
Intervention & Theory of Change

The intervention took place in select villages in Mirriah Department of Zinder Region, Niger, and Kurigram District of Rangpur Division, Bangladesh – two areas where marriage before 18 is particularly common. These locations were chosen in coordination with other international and local partners to ensure not to overburden local populations and to create linkages with other supportive interventions within the health system.

The intervention period was dynamic, with some activities transitioning to community or peer leadership while others, particularly the vocational training and income-generating components, required longer direct support from CARE before transitioning to girls, their communities and local civil society organizations. In Niger, the core components lasted from March 2019 to March 2021, with lighter-touch supervision and support to income-generating activities (IGAs) through July 2021. In Bangladesh, core components ran from March 2019 to March 2021, with training and support to some IGAs through January 2022. Participants included married and unmarried adolescent girls ages 15-19, their husbands, families and communities, as well as health workers. COVID-19 mitigation strategies – including government-mandated lockdowns and restrictions on travel and group activities – interrupted some program activities from April to June 2020.

Theory of Change

When married adolescent girls are equipped with critical resources, skills and competencies and are supported by their family, community and the systems that surround them, they are empowered to plan their futures, exercise their agency, and envision and pursue their aspirations. This premise is captured in the project theory of change, which guides the overall intervention approach.



Intervention Components

- **Girls' Collectives:** Led by trained female facilitators from the region, each group was made up of approximately 15-25 girls ages 15-19 from a single village. Girls followed a 27-session, participatory curriculum that addresses puberty and other reproductive health topics, decision-making, communication skills, gender and social norms, collective action and leadership, and a range of other issues.[1] The sessions also served as a platform to connect girls with community health workers and women role models, and as an entry point for training on business and entrepreneurship skills that serve as a foundation for additional vocational training and IGAs. Participants also had the option to establish, join and participate in parallel Village Savings and Loan Association (VSLA) groups, supervised by field facilitators and trained adult mentors, to grow their savings and access loans to support their IGAs.

- **Vocational Opportunities:** CARE worked with private- and public-sector actors to establish partnerships and training support for adolescent girls in a number of key market systems identified as well-suited for girls' participation through a market analysis.[2] In Niger, these included cowpea processing and refinement, goat breeding and management, and feed/fodder services/input sellers. In Bangladesh, enterprises included cotton and jute handicraft production, mobile phone retail and repair, digital / IT services. After girls completed their trainings, CARE continued to work closely with partners to create market linkages for girls through internship opportunities, craft fairs, professional associations and ongoing mentorship. In Niger, this component also included more general marketing of cowpea and feed / fodder products to the general public to strengthen the customer base for girls' products.

[1] https://www.care.org/wp-content/uploads/2020/11/English_Girls-Collective-Facilitator-Manual-1.pdf
[2] https://beamexchange.org/community/blogs/2018/9/21/market-systems-approach-and-adolescent-births/

- **Health Worker Transformation:** Drawing on CARE's Social Analysis and Action (SAA) approach[3], trained facilitators led health workers on a 10-session, participatory curriculum that supported providers to build their adolescent family planning counseling skills while also assessing the ways that their beliefs and biases enable or impede their ability and willingness to offer nonjudgmental, rights-based sexual and reproductive healthcare to adolescents.[4] Providers also created individual and facility-level action plans to improve health services for adolescent clients. This complemented broader health system strengthening efforts by partners in the region, to ensure adapted, responsive care for adolescent clients. In Zinder, IMAGINE partnered with Pathfinder's IMPACT2 project, which already was working to train health workers in clinical skills in FP service delivery, and ensure supply of FP commodities, in an effort to ensure that IMAGINE's 41 intervention villages were included in outreach service activities (community-based distribution of contraceptive commodities, conduct mobile clinics and fairs).
- **Fada Groups**[5] (Niger only): To engage young men and husbands as allies, trained male facilitators from the region delivered a comprehensive curriculum to existing men's social clubs called Fada groups. The interactive curriculum was designed to provide men with the tools, knowledge and self-efficacy to champion delayed first birth. Each group of 15-25 men followed a 15-session curriculum designed to enhance their knowledge related to sexual and reproductive health, relationships and financial literacy. Sessions address the health and economic benefits of delayed first birth, communication skills, and gender and social norm transformation, and also support men's leadership potential by providing them with the skills and tools to lead awareness-raising activities in the community.
- **Community SAA** (Niger only): Using the SAA approach, CARE led community stakeholders through a process of critical self-reflection and action planning to challenge social norms that encourage early birth and to build norms encouraging nulliparous married adolescents' access to essential health services, including family planning and pursuit of alternative pathways. Each group was mixed-gender, made up of key community influencers from a single village, including mothers-in-law, religious leaders and healthcare workers. Participants followed an eight-session, participatory curriculum facilitated by trained local facilitators with support from elected male and female co-leaders. Sessions explored beliefs around gender roles, reproductive health and other topics that underpin early childbearing. Community SAA groups also worked in partnership with local Fada and girls' groups, ultimately forming cross-cutting management committees to create an enabling environment for first birth through joint action plan development and collaborative implementation.
- **Couples Counseling and Newlywed Kits (Bangladesh only):** Trained facilitators delivered a nine-session, interactive curriculum in a couple's home over a three-month period covering goal setting, family planning, communication and negotiation, financial planning, and sexual and reproductive health and rights (SRHR) social norms reflection, to empower couples to create a vision for their family. Some sessions also include extended family members in order to reduce potential backlash and engage them in the couple's journey. As part of counseling, frontline health workers periodically visit newlyweds in their home to provide additional information on family planning and to strengthen the couple's link to the formal health system. In addition, couples also receive a Newlywed Kit, which includes FP information, condoms, and activities to support couples' communication and joint decision-making. As the counseling sessions progress, couples are invited to participate in couples' events, community-based activities such as performances and cooking competitions to promote supportive social norms around gender equality and timing of first birth.

[3] https://insights.careinternational.org.uk/images/in-practice/Gender-in-the workplace/SAA.GlobalImplementationManual_FINAL.English.rights-reserved_2018.pdf
[4] https://www.care.org/wp-content/uploads/2020/11/English_Health-Workers-Manual.pdf
[5] https://www.care.org/wp-content/uploads/2021/10/English_Fada-Facilitator-Manual.pdf

Evaluation Aim & Objectives

The overall aim of the qualitative evaluation is to examine if and how key participants and stakeholders in each community are experiencing the change in norms around delaying early adolescent childbirth stemming from the IMAGINE intervention, and which intervention pathways were most resonant for participants.

To capture the influence of various intervention components on the stated aim, this evaluation addressed four specific questions:

1. **In what ways, if any, have attitudes and behaviors that support/ impede delaying early childbirth/ alternative futures among married adolescents changed since the onset of intervention activities?**
    a. How have these norms changed within specific influential groups (adolescents, husbands, influential adults in adolescents' lives, community members)?
2. **What, if any, changes took place in married/unmarried adolescent girls' ability to …**
    a. Envision a future that includes possibilities beyond immediate childbirth?
    b. Participate in vocational activities that increase their agency and assets to delay childbirth and pursue alternative futures?
    c. Communicate with influential figures in their lives about delaying childbirth and/or pursuing alternative futures?
    d. Access and be satisfied with SRHR?
3. **In what ways, if any, did the intervention impact couples' ability to make fertility/SRHR choices that support delaying childbirth?**
    a. What have been the specific experiences of husbands versus married adolescents?
4. **In what ways, if any, have health workers changed their capacity (attitudes, behaviors) to support delaying childbirth among married adolescents?**

Methods

Study design

To understand the impact of the IMAGINE project on attitudes and behaviors around delaying early adolescent childbirth, we used a variety of post-intervention evaluation methods on a non-probability sample of participants. Methods included in-depth interviews (IDIs) and focus group discussions (FGDs) and made use of vignettes and case studies to illustrate the effects of the intervention and facilitate participants' reflections on what is expected or typical in their communities and whether or how this has changed in recent years. All data collection was guided by the Qualitative Impact Protocol (QUIP)[6] methodology, which uses a standardized data collection process to generate credible causal links between project activities and changes in intended beneficiaries.

Study setting

Qualitative data collection took place in locations where intervention activities occurred: select villages in Mirriah Department of Zinder Region, Niger, and Kurigram District of Rangpur Division, Bangladesh. Specific villages were selected in consultation with local stakeholders on the basis of both accessibility and suitability for research, given the final roll-out of activities. A non-probability sample of adolescents, their partners, community members and health service providers were selected from the region using a combination of purposive and snowball sampling methods (further described below).

Target populations, sampling strategy, inclusion/exclusion criteria

[6] The Qualitative Impact Protocol Casebook http://bathsdr.org/wp-content/uploads/2017/09/Revised-QUIP-briefing-paper-July-2017.pdf

Below, we define each target group for end-line evaluation participation and sampling strategy, inclusion/exclusion criteria and recruitment procedures. Table 1 describes the sampling strategy and sample size for each participant group in the evaluation. This formula was applied in both Niger and Bangladesh. Data collectors aimed for either the full participant size or saturation, whichever came first.

- **Married adolescent girls:** The IMAGINE project reached married adolescent girls ages 15-19 through the Girls' Collectives and vocational opportunities. To be included in the qualitative evaluation, married adolescent girls must have completed the minimum required number of sessions for each intervention component, as defined by program leaders. Girls who did not complete the intervention were excluded. For IDIs with married girls, two subgroups were selected: 1) married adolescent Girls' Collective participants who delayed birth during the program, and 2) married adolescent Girls' Collective participants who did not delay birth during the program.

  Married adolescent girls who met the inclusion/exclusion criteria were purposively selected from among a roster of Girls' Collective participants using program data. CARE field staff and IMAGINE peer educators were consulted during the selection process to ensure that the participants represented a range of adolescents. Each field facilitator was asked to identify, from the participants of the Girls' Collective in their four villages, four girls: two who were married and were believed to have decided to delay their first birth, and two who were married and had become pregnant or had a child during the IMAGINE project period. Of the two pairs of married girls selected (those that had had a child and those that had not), we requested that at least one girl in each pair had participated in one of IMAGINE's vocational training activities. When selecting these participants, we also asked that among those who met the inclusion criteria, field facilitators select those who were likely to provide rich information and be dynamic respondents.

  Girls' Collective participants: In addition to in-depth interviews with married adolescents, we also conducted more general focus group discussions that included both married and unmarried girls and those who had and had not begun childbearing. We conducted these discussions with existing members from groups that met our inclusion criteria. We selected three Girls' Collectives at random from among all those that met the following criteria: The group had been active as of the end of the implementation period; the group had an average participation rate of at least 80%; and the group's peer educators remained active.

- **Husbands of married adolescent girls:** Husbands were involved in Fada/SAA groups (Niger) or couples counseling (Bangladesh) and thus are an important group for this evaluation. They also are included in the case studies of specific adolescent girls and their experiences with change through the project. To be included in the evaluation, husbands had to be either connected to and referred by a married adolescent girl who participated in the IDIs, or a participant in either the Fada groups or the couples counseling activities in Niger and Bangladesh, respectively. Husbands were selected using both random and purposive methods. Husbands whose data were collected for the case studies were referred to the study team by their wives (~6 of the husbands will be selected this way). The remaining six husbands were identified by the field facilitators from a list of Fada and couples counseling participants that had participated in a majority of sessions.

- **Influential people in adolescents' lives:** For select adolescents, influential people also were interviewed as part of the case studies. These individuals, who were identified by the adolescent married girls who participated in the IDIs, were not required to have participated in any intervention activities.
- **Community members:** To better understand how community-level attitudes and behavior around early child-bearing and alternative lives for young girls have changed, we conducted FGDs with males and females who were involved in community activities (in Niger) and those who did not

receive direct interventions. For FGDs with community members in Niger, we asked each field facilitator to identify one village among their four that had an active SAA group as of the end of implementation, where the average participation rate was 80% or higher, where peer educators were active, and whose field facilitators determined that members would be able to provide rich information in response to our group discussion guide. We also conducted discussions with community members who had not participated in SAA activities. These individuals were selected at random from a list provided by village chiefs or community leaders.

In Bangladesh, though there were no activities that engaged the general public, we still conducted FGDs with community members to get a sense of broader changes experienced from their perspective. Village leaders and existing local contacts were asked to mobilize interested male and female community members/peers to participate in these FGDs. These discussions were held separately among male and female participants.

- **Health service providers:** The evaluation examined changes in providers' beliefs around delaying childbirth and use of modern methods among adolescent girls. Participants were purposively selected from among those who participated in the intervention that was delivered through public health facilities that served the intervention communities. Healthcare providers (n=10) were purposively selected from among those who received the Health Worker Transformation intervention based on their completion of the intervention and availability at the time of data collection. The sample was selected to represent a mix of provider types from across the cadres who participated in IMAGINE.

Table 1: Sampling Strategy and Sizes for Evaluation

* In Bangladesh, we recruited three male and three female FGDs (~ eight people each) without differentiating between "exposed" or "unexposed" due to the intervention design in that country.

Group	Qualitative Method	Sampling Strategy	Target Sample Size in Each Country	Target Total # of Participants Per Country
Married girls	IDI	Purposive	12 "delayed," 12 "not delayed"	24
Girls' Collective participants	FGD	Random	3 FGDs, ~8 per group	24
Husbands	IDI	Purposive/random	12	12
Influential adults	IDI	Purposive	12	12
Healthcare providers	IDI	Purposive	10	10
Community members*	FGD			
Female exposed		Purposive	3 FGDs, ~8 per group	24
Male exposed		Purposive	3 FGDs, ~8 per group	24
Female exposed		Random	3 FGDs, ~8 per group	24
Male exposed		Random	3 FGDs, ~8 per group	24

Recruitment

Adolescents, husbands, family members and community members who participated in intervention activities were approached by field data staff for participation in the evaluation. They were located

using either program data on their household and/or through consultation with community health workers or community leaders who could identify their location. Health workers were reached at their place of work, or in the case of community health workers, within the community, using program records. Community members who were not exposed to IMAGINE activities were recruited directly from the village by approaching prospective participants with the support of community leaders.

Data methods

Below is a set of qualitative approaches that were used among target groups to facilitate our understanding of the IMAGINE project impact.

- **In-depth interviews:** We conducted IDIs among a sample of IMAGINE project participants, including healthcare providers, married adolescent girls (with or without children), married girls' husbands (or partners), and influential adults in the adolescents' lives as identified by the girls themselves, such as mothers, fathers and other elders/relatives. Using the QUIP approach, individuals were asked about perceived changes in key topics related to the IMAGINE goals and objectives (e.g., changes in attitudes, behaviors in support of delaying early childbirth and pursing alternative futures for adolescent girls). They were then asked to specify why and how they think these changes took place (without direct mention of any intervention activities by the data collector) to provide an unbiased source of attribution from IMAGINE participants themselves.
- **Focus group discussions:** We used FGDs with Girls' Collective members as well as community members of the intervention villages to determine the impact of IMAGINE activities on overall attitude and behavior changes at the community level. Where necessary, focus groups were separated by gender. As with the IDIs, FGD questions were structured in an open-ended manner that referred primarily to changes in desired outcomes, and did not refer specifically to the intervention components themselves. Participants then were asked to trace where they believe changes in attitudes and behaviors stemmed from in their communities.
- **Vignettes:** We used vignettes (a qualitative technique that uses a short story or situation to elicit responses to a particular scenario) to describe a hypothetical young married girl who decides to delay childbirth and pursue an income-generating activity. We employed vignettes to clarify both participants' attitudes and beliefs around this topic and their perception of the attitudes, beliefs and expectations of those in their communities more generally, and to elicit any changes in behaviors/attitudes over the period of intervention, using the CARE SNAP methodology[7] as a basis. These vignettes were used both in IDIs and FGDs and were customized to the specific outcome expectations for each group, based on our theory of change.
- **Case studies:** Using data from the IDIs – with select specific adolescents and their respective husbands/partners and other influential adults – we developed case studies of particular adolescents and their experiences of change having gone through the IMAGINE project. Case studies focused on select adolescents who underwent positive change and/or were able to delay birth and those who were not, as a means of differentiating key differences in their experiences with the IMAGINE project. Adolescent candidates for a case study were purposively selected using data indicating their participation in the project and outcome of delayed birth since the project inception.

Data collection

Data collection took place April 7-19, 2021, in Niger and November 6-15, 2021, in Bangladesh. Field staff were recruited locally and trained to collect data, supervised closely by a third-party research firm and the principal investigator. When identifying data collectors, considerations were made for field staff familiar with the target communities and fluent in the local languages as well as national languages. All field staff were trained on the study instruments and tools, best practices in the administration of the

[7] https://insights.careinternational.org.uk/images/in-practice/GBV/GBV_care-social-norms-paper-web-final_2017.pdf

instruments, and ethical protocols during and after fieldwork, including psychological first aid for survivors of gender-based violence (GBV), in the case of disclosure during data collection, and GBV-related service referral resources and procedures. A field-based data quality system was developed and implemented to ensure high-quality data. Spot checks were adopted to minimize data manipulation and falsification.

Trained field staff collected IDI and FGD data using pre-tested semi-structured guides. In Niger, these guides were written in English and translated into French. The written guides then were orally translated from French to Hausa during the field staff training week to ensure uniformity. In Bangladesh, guides were developed in English and translated to Bengali. Data were collected by trained interviewers in the local language and all interviews were conducted in a private location. All interviews were digitally recorded, and recordings from Niger were transcribed into French and in Bangladesh into English. Interviewers also took notes to document their observations during the interviews.

Data analysis

All data from interviews and focus groups were transcribed and translated from the original language into French in Niger and into English from Bangladesh then analyzed for content. A sample of the recordings were reviewed by the study manager, who listened to the recording and checked for accuracy of the corresponding transcript. Our analysis involved coding the data using the structures and themes of the interview guides, developing a list of emerging themes, categorizing the themes within a hierarchical framework of main and sub-themes, looking for patterns and associations between the themes, and comparing and contrasting within and between the different groups of participants. Where there were questions or discrepancies, we verified findings by multiple members of the research and intervention teams. We used qualitative analysis software (MAXQDA) to support these analyses.

Results

Demographic background

Table 2 shows the basic demographics of married girls, husbands and healthcare workers. School attendance among married girls (regardless of childbirth status) is 100% in Bangladesh and 58% in Niger. In Bangladesh, almost none of the married girls have jobs (9% of married adolescent girls with a child, 0% with no child), while in Niger, 33% of married adolescent girls without children and 58% of married adolescent girls with children engage in income-earning activities. Husbands in both Bangladesh and Niger are considerably older than their wives, and the majority are employed. In Bangladesh, all but one of the healthcare workers interviewed worked primarily in the provision of community-based services outside of formal health facilities; in Niger, 60% were community health workers.

Table 2: Basic Demographic Characteristics of Participants

Participant Type	Average Age	% Who Attended Any School	% With a Job
Married adolescent girl with no child (n) Niger (12) Bangladesh (11)	 17.8 19.8	 58.3 100	 33.3 0
Married adolescent girl with child (n) Niger (12) Bangladesh (11)	 18.9 20	 58.3 100	 58.3 9.1
Husband (n)			

Niger (12) Bangladesh (12)	30.3 28.3	75 100	75 91.7
	Average # of Years Working	**% Community Health Worker**	**% Other (Nurse/Midwife/ Physician)**
Healthcare provider (n) Niger (10) Bangladesh (7)	 9.6 13.1	 60 100	 40 0
	# of FGDs		
Girls' Collective FGD Niger Bangladesh	 3 3		
Community FGD Male Niger "exposed" Niger "unexposed" Bangladesh "unexposed"	 3 3 3		
Community FGD Female Niger "exposed" Niger "unexposed" Bangladesh "unexposed"	 3 3 3		

Thematic organization of findings

Findings are presented around the key evaluation questions in each country:

- **EQ1.** In what ways, if any, have norms that support/ impede delaying early childbirth/ alternative futures among married adolescents changed since the onset of intervention activities?
- **EQ2.** What, if any, changes took place in adolescent girls' ability to …
  - **a.** Envision a future that includes possibilities beyond immediate childbirth?
  - **b.** Participate in vocational activities that increase their agency and assets to delay childbirth and pursue alternative futures?
  - **c.** Communicate with influential figures in their lives about delaying childbirth and/or pursuing alternative futures?
  - **d.** Access and be satisfied with SRHR services?
- **EQ3.** In what ways, if any, did the intervention impact couples ability to make fertility/SRH choices that support delaying childbirth?
- **EQ4.** In what ways, if any, have health workers changed their capacity (norms, attitudes, behaviors, services, etc.) to support delaying childbirth among married adolescents?

In addition to these questions, we explored the nuance and range of experiences among married adolescent girls using four key case studies. These case studies include two girls who delayed pregnancy/childbirth during the intervention and two who did not.

➢ EQ1: Norm change for delaying birth/pursuing alternative futures

NIGER

Positive shift in norms around delaying birth

Respondents were asked to share their impressions about changes in local attitudes or behaviors toward delaying childbirth among adolescent girls. A number of participants noted a positive shift in support for delayed birth when compared with previous years. This shift also is concomitant with the change in support for girls' pursuit of income-generating activities or training/work outside of the home. This was reflected both in response to a vignette depicting a hypothetical adolescent girl from a neighboring village, as well as lived experiences of the participants.

> *"In fact, there has been a real change. In the past, men did not let their wives delay their first births. But nowadays, with sensitization, they allow them to do so."* ***– Male Fada member, Diney***
>
> ***
>
> ***Interviewer (I):*** *In this village, in your opinion, has the support given to adolescent girls to delay their births increased or decreased?*
>
> ***Respondent(R):*** *"Really it has increased."* ***– Married adolescent girl, Koleram***
>
> ***
>
> *"Some people in the village will say that Samira[8] does not want to procreate by delaying a first pregnancy, and others will say that it is normal, since by doing this, she can have the chance to find a job or to promote a business. … Currently, there are people who delay pregnancy for three to four years before having a baby."* – ***Married adolescent girl, Kaouga***

The primary motivating factor behind the community's growing support for delayed early births is to protect the girl's health. Participants explained how delaying birth allows both mother and child to have a healthy birth outcome, and liken it to birth spacing, a practice that has been normalized in these communities in recent years. For a minority of respondents, considerations other than health, such as pursuit of education, also play a role in accepting delayed birth.

> *"We 100% support [delaying birth for two years], because it has a lot of advantages. The first advantage is that the woman will not have any problems during childbirth except as God has already decreed. There is great satisfaction because the baby will be healthy."* ***– Female community member exposed to intervention, Angoual Harou***
>
> ***
>
> *"Now people understand the importance of delaying pregnancies. If [consecutive] births tire a woman, she can take contraceptives to rest for two, three or five years."* ***– Married adolescent girl, Tossoro***
>
> ***
>
> *"In the past, we would be amazed at the decision of a married girl who is considering delaying her first birth, because it would seem foolish for her to do so. Today, we see that it is very well-founded for her to do so. Suppose it is a girl who studies at school – she will need time to assimilate her studies."* ***– Female community member, exposed to intervention, Djeda***

Lingering barriers to delaying birth

Alongside the positive shift in support for delaying birth, there *still* are some who stigmatize delaying birth, associating it with infertility or "loose" behavior on the part of the married adolescent girl. The stigma of infertility falls most squarely on *girls' shoulders,* sometimes in the form of mocking. Though the stigma remains, respondents said it does not outweigh the positive attitudes described above.

[8] "Samira" is the name of the hypothetical adolescent girl presented to participants in a vignette during interviews.

Rather, the stigma is seen simply as a barrier that adolescent girls face when they want to delay pregnancy.

> *"Religiously, it is not normal for a young woman to delay a pregnancy since she must first prove fertility. Birth spacing is only allowed if the pregnancies are close together."* ***– Male Fada member, Djeda***
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> *"Without knowing [her reasons], people will think that she wants to engage in prostitution and this is the reason why she delays pregnancy, while she just wants to put a life plan in place that she's built for herself. People will assume she has debaucherous plans if she expresses her desire to delay the pregnancy."* ***– Married adolescent girl, Angoual Harou***
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> *"There is a girl called Anana who was three years married without giving birth. One man laughed at her saying that her husband made a great loss by buying a goat that has no use."* ***– Female community member, exposed to intervention, Dogo Chaibou***

Moreover, there is a misconception among some community members (even those who wish to delay) that taking contraceptives prior to a first birth may impede future fertility.

> *"People will say she hasn't thought about it. Because the fact that she used contraceptives is stupid. She should be pregnant right away."* ***– Male community member, exposed to intervention, Kaouga***
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> *"There are those who use contraception to rest. There are those who seek advice before committing. But for the one who has never given birth, I would ask her to have the first child first. Then a few years later she can do FP if she wishes. I use the traditional method because that is what is available. Modern methods are not available, but even if they are available, they adversely affect the health of women."* ***– Married adolescent girl, Dogo Chaibou***

Positive shift in view of girls' pursuing income-generating activities

When asked specifically about norms around girls' participation in IGAs, most community members noted a positive shift. Contrary to several years ago, many now view girls' pursuit of work outside the house as a constructive development and one that could contribute to the betterment of her family and household.

> *"Things have changed because previously no one would let his wife have a business. But today we find ourselves in a situation where women buy and resell items that far exceed family consumption, and consequently, they support husbands through these activities. This is the consequence of the awakening of consciousness."* ***– Father of married adolescent girl, Angoual Harou***
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> *"I really encourage them because nowadays it is not every father who can take care of his household 100% in our village. If a woman does a business, she can meet some of her needs and contribute to the development of the household."* ***– Husband of married adolescent girl, Dogo Chaibou***

Income-generation alone may not justify delaying first birth

Though the majority of interviewees support girls' pursuit of IGAs, some said that these enterprises were insufficient justification for delaying a first birth. Unlike the protection of a girls' health – which

many cited as a legitimate reason for a girl to delay birth – a number of participants expressed that working outside the would not be deemed an acceptable reason for delaying birth. A female community member from Kaouga explains this tension succinctly: *"No, young people are not better supported than when they [delay] in the interest of protecting the health of the young girl. Even if, in fact, she will have to exercise economic activities, they must not be outside the matrimonial home. … Otherwise there is a risk that even her marriage will fall apart."*

Some girls themselves perceive that delaying birth simply to earn money may be an absurd prospect in the eyes of community members. When asked about the "perceptions of the community toward the woman who decides to delay her pregnancy in order to engage in an income-generating activity," many responded with negative views:

> *"People will say she is sick. Why is she going to delay her pregnancy to do an income-generating activity!"* ***– Married adolescent girl, Kaouga***
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> *"They will say that she spends all of her time hanging around from market to market selling products. They will say that is not a good thing."* ***– Married adolescent girl, Koleram***

Shift in norms attributed to IMAGINE

When asked about the reasons for positive norm change around allowing girls to delay birth and pursue IGAs, nearly every single participant cited community training or sensitization activities as the source. Furthermore, there were 150 independent mentions of CARE or the IMAGINE project as contributing to change.

> *"Frankly, the project has helped the population a lot because at present, certainly the people who delay births are less numerous than those who give birth, but more and more of them are asking us for information on how they can do it to improve their life and be able to flourish."* ***– Girls' Collective member, Djeda***
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> *"There is no longer any concern to discuss these issues of delaying or spacing births when, with the arrival of the IMAGINE project, all age groups have been sensitized and trained on this subject."* ***– Male Fada member, Dogo Maikassoua***

BANGLADESH

Support for delaying birth is on the rise

From husbands to married girls to community members, a variety of respondents noted changing attitudes and norms around delaying birth in their villages. Responses point to a gradual but steady change in both support for girls delaying a first birth and working outside of the home, a distinction they make from the past.

> ***R****: "If [Samira] earns money and supports her family, then people might realize that she knows what she is doing, and her acceptability will increase in society."*
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> ***I: Did the people also accept married girls for working outside earlier, suppose two or three years ago?***
> ***R:*** *"No, people didn't accept that before. They always used to say that married girls should stay at home and only husbands work outside. But gradually people's perceptions and attitudes will change."* ***– Married adolescent girl with no children, Jolpara***
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I: If a married adolescent in your community wanted to delay childbirth in order to work or attend training outside the home, what would be the response of in-laws?
R: *"Definitely good. They should allow their daughter-in-law to go outside for a job or training. They should say to her, 'Delay childbirth, so that you can concentrate on work. You should go for job or training and learn. After your learning or training, you will be able to do work that will boost your financial condition. You will be benefited.' In the past, they wouldn't allow their daughter-in-law to go outside. They would ask her many questions if she wanted to go outside for any reason. 'Where and with whom are you going,' etc. Now, everything has changed.* ***– Influential female, Jolpara***

Married girls themselves attribute this shift to a positive reinforcement loop occurring in communities: The more people see girls learning and working outside the home, the more acceptable it becomes for girls to do so.

In response to questions about how/why support for delaying childbirth has changed, four married adolescent girls in a female-only FGD in Garuhara replied:

R1: *"Before, [people in the community] did not understand that poverty can be mitigated by delaying childbirth. I mean one can earn a bit, progress financially and then conceive at a mature age. One can raise a child properly with that income. Now, when people see someone's daughter doing good work, they think, 'Let my daughter work, too. Maybe she will also get a good result.' In this way, gradually, every family is changing.*

R2:*"All us girls were united. We said, 'Someone else's daughter is working there, so you should let your daughter work as well."*

R3:*"Gradually, a change is taking place. … It has changed."*

R4:*"It has changed a lot."*

Some ambivalence toward delaying
Despite the perceptions of positive shifts, respondents described a general ambivalence toward girls delaying birth. In several cases, interviewees described something akin to a 50-50 split in support for delaying birth, based on peoples' "understanding" of the benefits.

"More than 50% of people support family planning, but 50% support the early birth method." ***– Husband of married girl, Bosuniapara***

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"Many families will receive it well and many families will take it badly. Those who do not understand will take it badly, and those who understand will not take it badly." ***– Influential female, Polashbari***

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"Some people would say that there must be some problems in the couple, which is why they are not having a child. Maybe the girl has some other plans; she will not continue this marriage. Those who think in a negative way would say such things. Those who understand, who think a good way, would say the couple is right. In this area, there are equal numbers of people. Some would say good things; some would say bad things." ***– Male community member, Jolapara***

Participants themselves attribute this ambivalence to certain demographic characteristics, noting that those in more rural areas, with less education and in older generations are less likely to support delaying birth or girls' pursuit of work outside the home compared with more literate and younger groups. This might suggest that being against delaying birth is increasingly considered an "old" or "backward" way of thinking in these communities.

> *"People have had a certain point of view for many years now. In our rural settings, if anyone's daughter marries late, people criticize a lot. If someone's daughter or daughter-in-law delays giving birth, they face huge criticism. Many illiterate and older women like grandmothers, aunties, mothers and mothers-in-law think that way. They think late marriage means problems. Early marriage means they got rid of the burden."* ***– Married adolescent girl, Kurigram***

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> *"Before my daughter's marriage, some people spread rumors about her. They criticized us for not marrying her off before she was 20. Most people supported [my daughter], especially those who are educated. They think, 'This girl is studying well; she will become a good human being.' On the other hand, those who are not well educated still have a negative mentality about girls' education and working outside."* ***– Influential female, Nilkantha***

Unlike in Niger, delaying birth is not interchangeable with spacing in Bangladesh. Several respondents noted a growing desire for fewer children and increasing acceptance in the community for both spacing and delaying. That said, some girls still face pressure to conceive a child shortly after marriage to appease the husband's family and stave off stigmatization from the community. This can impact both the timing of their first birth and their ability to access contraceptives.

> ***I: How was the situation in the past?***
> ***R:*** *"There has a vast difference between past and present. A family had at least four or five children. But now, people do not want to have more than two children. No matter if they have a boy or girl they are happy with their children. They are more aware now. Awareness is growing day by day. The government of Bangladesh, different NGOs and organizations have taken many steps to reduce child marriage and introduced birth control methods.. They made us aware."* ***– Husband of married girl***

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> *"The main obstacle for an adolescent married girl who has no child is her family – her husband and her in-laws. 'You must conceive now. You cannot use any contraceptive method.' But an adolescent married girl who has a child already, if she is not ready to conceive another child, she can use contraceptives to delay her childbirth.* ***– Healthcare worker, Kurigram***

Financial security cited as primary factor driving desire to delay, with health as secondary

The majority of respondents in Bangladesh mention money or financial stability as a key factor in supporting delaying birth. Respondents link early birth with increased poverty and see girls' work outside the home as a positive contribution to the overall well-being of the family. Husbands in particular cited economic reasons as a major incentive to support girls delaying and pursuing work outside of the home.

> *"If a couple delays childbirth, they will improve their family earnings and bring financial stability. Both husband and wife can work together. Girls get time to prepare themselves physically to conceive. Yes, parents should think about their future and plan how to manage their family after giving childbirth. Also, they need to help their child be a good human being. Otherwise, the meaning of childbirth and rearing livestock would be identical."* ***– Influential female, Jolapara***

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I: But if we compare with before, do you see a change in people's point of view in terms of delaying early childbirth? Or about conceiving?
R: *"Of course, there is a change. There are benefits for delaying early childbirth. There are lot of savings as well. There are many expenses with a child. If our income is 400 taka a day, but I have to spend 1,000 taka for the child, then there will be a lot of deficits. Try to understand the calculation! In that case delaying early childbirth is good."* ***– Husband of married girl, Attaram***

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"Parents should earn first and save money for the future. There are many expenses to properly raise a child. Those who think this way would say positive things [about delaying early childbirth]. Those who have still follow the culture of early pregnancy would say negative things." ***– Male community member, Jolapara***

Participants support married girls' pursuit of education as a path out of poverty. Education is seen as a steppingstone to greater economic prosperity, and many respondents noted a recent increase in support for girls' education in lieu of both early marriage and early birth.

"My views are positive on this. I believe conceiving late is good, because then the family will be educated and the girl... she might be involved in educational or any other organizations, her mentality will be very different. The family will think that we will have a child, but first we need to build a house and work to have a child. [Whereas] today we are living in one bed." ***– Husband of married girl, Char Gobindopur***

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"Now the importance of education is raised in people's mind. People are understanding that there is no way without education. If girls study, then they will have a better life. Value for education wasn't there [before]. Now [it has] progressed. There is education in every house now. There is change, as in [people] are seeing it now and understanding that education has more value." ***– Married girl, Nilkantha***

In addition to educational and economic motives, numerous respondents cited the health of girls and their babies as a reason for delaying early birth – although it was mentioned less frequently than money. There is an understanding that with childbirth under a certain age (18-20), girls and their babies are at risk. Furthermore, there are indications that delaying early birth is becoming a norm in these communities, as people see more girls in their villages delay birth.

"If [Samira] decides to have a child when she is physically ready, that would be great." ***– Influential female, Jolapara***

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"[Delaying birth] is good in my point of view – good in every way! It is very beneficial for the body. If a girl delays early childbirth, then mother and child both will stay well.". ***– Married girl without child, Attaram***

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"I've learned a lot from girls who marry and live happy lives and are in good health. Furthermore, my neighbors share their knowledge with me. If girls marry later in life, they can work and have children without experiencing any health problems." ***– Married girl without child, Garuhara***

When asked where the changes in attitudes toward early birth stem from, nearly all participants cited either the IMAGINE project or the Kishori Clubs (Girls' Collectives) as sources of education and learning (with more than 200 independent mentions).

"Yea, there was a project named 'IMAGINE project'.I received training and worked there. They have made us aware of the difficulties of child marriage. They taught us to be self-sufficient first to support our family and take responsibility for our children. … When a young married girl suffers from malnutrition, the mother and newborn baby will suffer from various complications after giving birth. Many children may bear a handicap. IMAGINE taught us to take steps so that children will be born healthy." – ***Husband of married girl, Bosuniapara***

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R: *"Couples have to make families understand what kind of problems they may face if they have a baby early. If they describe it correctly, people will understand. There are much fewer [barriers] than before."*
I: How have these changes happened? What are the reasons behind that?
R: *"Various clubs, NGOs and organizations, along with some sisters and brothers, have spread awareness, and now people can understand. Previously, there was no awareness and people had no idea. Now we have a Kishori club in every village.* ***– Married girl without child, Polashbari***

Use of modern contraceptive methods is mostly accepted
Acceptance of modern contraceptive methods tracks along parallel lines with changes in attitudes toward delaying birth. For the most part, those who are supportive of delaying birth among married girls also encourage use of contraceptive methods to do so. Further, as acceptance of delaying childbirth has increased in recent years, so has openness to family planning among married girls. This improvement in attitudes is accompanied by explicit knowledge of method types and their uses.

I: If a girl in your area wants to delay childbirth, she needs to use contraceptive methods. When she uses any method, what do the people in your area think about that?
R: *"No one really knows if anyone is using any method. I think they use it secretly. When others see that it has been a year but no baby is born, then they assume that there must be some methods taken. People's perceptions have improved. It is good to use modern methods."* ***– Husband of married girl, Jolapara***

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"People are becoming more aware than before. The Bangladesh government supplies different methods to prevent or control childbirth. A newly married couple can use contraception or they can decide to give birth after two or three years of marriage. The duration of the injectable method is three months. This method is helpful for them." ***– Husband of married girl, Jukripara***

Just as with the overall topic of delaying birth, we also see ambivalence in the community around use of family planning methods.

"Some says contraception is good, and others suggest not using it and having the child early. They say, 'Don't use this. The marriage/family won't be sustained,' etc., etc. Some others suggest, 'Delay childbirth; it will be good for the future. You will be fine, and your child's health will be good.' " ***– Married adolescent girl with child, Jolapara***

Without prompting, a number of respondents credited the IMAGINE/Kishori intervention for the positive changes in attitudes toward modern contraceptive methods.

I: What did you think about the family planning method when you married?
R: *"Honestly, I didn't think deeply about the family planning method. I thought if my wife conceived, we would accept it. After working with the IMAGINE project, I have changed my thinking and adopted the family planning method to save more money for my future child."*
–Husband of married girl, Bosinupara

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R:*"There were three to four children in each family because they were unaware of the family planning method. But the situation is changing. People are very conscious about family planning, and now they have only one or two children."*

I: How have the villagers changed their attitude toward family planning now? How are they becoming aware? Is there anything that has made them aware of the adoption of family planning methods?

R: *"Kishori organizations and health workers visited our village and made women and girls aware of family planning methods to gradually change their attitude. Now the villagers support family planning."* ***– Husband of married girl, Nilkantha***

The stigma of infertility is extant, but not overly prominent in these communities. Only a minority of people indicated pressure to conceive one child first before use of a contraceptive. These same people hold misconceptions of the side effects of modern methods on future fertility, as illustrated by this focus group discussion among females in the community of Garuhara.

I: OK, so if you use a contraceptive method before your first childbirth, you cannot conceive later?
R6: *"After having the first child, you can use methods."*

I2: And if there is no child then?
R6: *"You already have a child, so it will be enough. This is what people in society say."*

I2: Suppose one did not use contraceptive methods before the first child, but they did before the second. Would there be any problems in that case?
R3 *"No."*

I2: Would there be any barriers?
Several respondents: *"No, no."*

I: If they have no children at all, what would people say to them?
R6: *"Then people will call her banji (infertile)."*
R7: *"Infertility problem (laugh)."*

I2: Because they don't have any child at all?
R6: *"There is no child. They have been married for so long."*
R5: *"Either the man is impotent or the wife is barren."*
R4: *"Run to the hospital and do some checkups."*
R5: *"Find out whether they are able to produce or not."*

➢ EQ2: Change in girls' ability to envision the future, pursue vocational activities, communicate and access sexual and reproductive health services

NIGER

Girls envision a brighter future, but this still always includes children
When asked to describe their futures, girls were able to articulate a clear vision that includes more possibilities in the realm of vocational activities or pursuits beyond the traditional path of rapid

succession childbirth. This is a stark departure from CARE's baseline formative research in 2017, where many girls struggled to describe much beyond their immediate day-to-day activities.[9]

> *"My big project in the future is to have enough knowledge that will allow me to sensitize and train other people like you are doing with us now."* ***– Married adolescent girl, Dogo Chaibou***

Girls also are able to articulate how delaying childbirth will ease their ability to create IGAs and improve their economic situation. As one girl describes it below, before IMAGINE, once she is married off, she might have considered delaying her first birth for fear of having a daughter, as she would have a hard time providing her dowry.

> *"But now, if I manage to delay my first birth and start a business, even if I have a daughter, before she reaches the age to get married, I will have planned everything. I can sell products and save money while I wait to have my children. If a person does not [delay] and has a lot of children that she struggles to feed, it will be difficult for her."* ***– Girls' Collective participant, Djeda***

While recognizing the benefit of delaying first birth, girls do not seem to make a binary distinction between early childbearing and pursuing vocational activities. It is clear that in girls' minds, one does not necessarily preclude the other, and while the connection between delaying birth and more easily pursuing income-generating activities was quite clear, the concept of making such a decision with the explicit purpose of being able to engage in IGAs appeared almost foreign to respondents in Niger. We see that for many girls, the idea of a rich future includes both children and IGAs.

> *"I think, God willing, in 10 years I will have three children and three to four head of sheep. I think if can make my dreams come true, I would like to have a business preparing and selling doughnuts."* ***– Married adolescent girl, Tossoro***

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> *"I am envisioning a lot of things. I don't have a child, so I will dream of having one in a few years. I can hope for many things in my life."* ***– Married adolescent girl, Rigal Djatou***

Further, having a child need not spell the end of girls' income-generating ambitions.

> *"I had made the decision to start a business. Unfortunately, the day before I was going to begin my business, I went into labor. It wasn't possible for me to do it in this state. But please God, as soon as I return to my in-laws, I will start a business."* ***– Married adolescent girl, Diney***

Agency has improved somewhat, but husbands often still have final say in girls' lives

Some girls report an improvement in certain aspects of their agency, such as the ability to make certain daily choices and to advise or discuss larger decisions with their husbands. This change is attributed to broader shifts in norms at the community level as well as to the skills and capacities girls have developed as a result of participating in project activities.

> *"Frankly, in the past, people were not able to view [delaying birth] positively because they were not aware. But today, many people understand, and girls can make such a decision in order to help themselves, their husbands, their families and the children they are going to have."* ***– Girls' Collective focus group member, Diney***

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[9] Samandari G, Grant C, Brent L, Gullo S. "It is a thing that depends on God": barriers to delaying first birth and pursuing alternative futures among newly married adolescent girls in Niger. Reprod Health. 2019 Jul 18;16(1):109. doi: 10.1186/s12978-019-0757-y. PMID: 31319853; PMCID: PMC6637607.

> *"There is a real change in my ability to make my own decisions. Even when my husband is present, I defend my right to take enough time after my first child before having another. When I started working with this project, my husband was away. After his return, he helped me pay my contributions."* ***– Married adolescent girl, Rigal Diataou***

However, the quotes above are more the exception than the rule when it comes to girls' capacity to make decisions around their fertility and vocational pursuits. There are more than 200 mentions of the need for "consent" when it comes to girls' decision-making around timing of first birth, contraceptive use or pursuit of IGAs, and the vast majority of these are linked to the husband. Furthermore, even when girls pursue IGAs, their earnings are at the disposal of the husband. This issue is further explored in relation to Evaluation Question #3 below.

> ***I: Regarding decision-making within the family, has there been a change?***
> ***R:*** *"No, the wife can consult her husband so that he can manage the few means which he has at his disposal thanks to her business."* ***– Married adolescent girl, Djeda***
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> ***I: In the story of Samira that I told you already, the husband completely agrees that she does [delay birth].***
> ***R:*** *"In any case, it is the husband's opinion that counts the most."* ***– Girls Collective focus group participant, Diney***

Access to – and satisfaction with – SRH has improved

Almost unanimously, girls note an improvement in the quality of SRH services and providers' attitude, comportment and willingness to support the use of family planning methods. They describe friendly services based on rights and choice, and report satisfaction with and access to services, especially at the community level. They also trust their providers' knowledge of and dedication to protecting girls' health. When asked about how a theoretical girl named "Samira" from a neighboring village might be treated by healthcare workers, girls responded positively.

> *"[Providers] will welcome her with the necessary respect because they know that she is an underage girl who was given in marriage and in the event of childbirth, she will suffer. Because of this, they will not hesitate to give her products."* ***– Girls' Collective focus group participant, Diney***
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> *"She will be greeted by the health workers and they will ask her what she needs to delay pregnancy. She will express her needs to them, and then the health workers will provide what is appropriate for her body. For planning issues, information circulates by word of mouth in the village and through NGO workers, who raise awareness. If the questions are ignored, there is a relay at the village level, where the interested parties get supplies."* ***– Married adolescent girl, Kaouga***
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> *"I was very satisfied with this visit [to the health center]. I was able to ask the health worker what I wanted to know about contraception. I received the necessary explanations, which enabled me to understand what I wanted to know."* ***– Married adolescent girl, Tossoro***

Participants describe a change in their own ability to access these SRH services, reporting increased knowledge of methods, confidence in using contraception and capacity to discuss various methods with others in their lives (such as friends or sisters). Girls also are able to name and describe a variety of methods, including pills, injectable and implants.

"In the past, women would justify their refusal to go and ask for planning services because of their husbands' refusal. But thanks to the first successful experiences of using the products, the women eventually convinced their peers to use the products. From that moment on, many women are now interested in this service." ***– Married adolescent girl, Rigal Djataou***

Myths, supply issues and need for a husband's consent may impede contraceptive use

Though girls reported increased trust in and access to SRH services, there still are obstacles that may prevent them from fully exercising their reproductive choice. Despite demonstrating knowledge of methods and a willingness to use them (particularly for spacing), some girls still believe that hormonal contraceptives can interfere with fertility and/or that they should first demonstrate their fecundity before using any modern methods. These beliefs may be reinforced by those close to the girl, such as her husband or family.

"Here, generally, a woman must have a [first] pregnancy, because if she tries to take contraceptives, it may be that God has already decreed that she could not have children. So, she should try to have a birth before starting to use contraceptive products." ***– Girls' Collective focus group participant, Kaouga***

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"Really, a lot of people will take her for a foolish girl, because they believe it is not normal for a woman to start taking birth control products without knowing whether she is fertile or not." ***– Married adolescent girl, Rigal Djatou***

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"According to [my husband], after the first child then we can practice [family planning], as we have the guarantee that we can give birth. We cannot space without the first child. It's very risky." ***– Married adolescent girl, Dogo Maissouka***

Cost and lack of supply also may create barriers for girls seeking to use contraceptives. Some girls describe a lack of availability at their local health centers, and point to the price of commodities as a potential barrier.

"The problem may be meeting the beneficiary's request [for a contraceptive method]. Is there product availability or not?" ***– Married adolescent girl, Angoual***

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I: How do you compare the quality of the reception given to young married girls without children requesting the family planning service in health centers compared to the last two years?

R: *"Now the service is faster. As soon as a woman goes to a health center, she is quickly served. But access has decreased. Women struggle to find products, and even if they are available, they have to pay for them with their own money."* ***– Married adolescent girl, Rigal Djataou***

Finally, a significant barrier to girls' reproductive rights and choice may be providers' insistence on confirming husband's consent before they give girls a contraceptive method. Several girls from various villages touched on this topic, some describing their personal experience while others explained their perception of how providers treat married girls seeking contraceptive methods. In some cases, consent may be required from another family member such as a mother or guardian.

"If she goes to the health center and explains why she came, the first question that will be asked is: 'Why did she not come with her husband? Does he agree or not?' Then, she will

undergo various tests to find out which method suits her best. She will be asked if she came with her husband's consent or it is just because she learned about it in the village? When they are convinced that it is indeed the husband who authorized her, they will give her what she wants. But if they are not convinced, they will tell her to come back with her husband so he can confirm it himself." ***– Girls' Collective focus group participant, Djeda***

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"They will first find out if she has her mother's agreement before they will give her what she wants. But even if she has her mother's consent, if her husband is against it, [they will not give her what she wants]." ***– Married adolescent girl, Garin Galadima***

BANGLADESH

Girls have a vibrant vision of the future, beyond childbirth

Married girls in target communities were able to clearly articulate a vision for their lives that goes well beyond immediate childbirth. When asked about their futures, girls expressed a desire to continue their education or participate in income-earning activities. They were focused not only on bettering their own lives, but on improving the condition of their families, including any future children.

"I dream that I will make a beautiful house. Then after few years, I mean after reaching a proper age, I will conceive a child. I will make a good family with husband and child. The child will grow older. So, for her future, some savings is important. This is my dream. There can be many dreams in one person's mind." ***– Girls' Collective member, Jolapara***

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"I will continue my education. Then, after completing my training on handicraft, I will provide such training to girls like me who are helpless or deprived. In the beginning, we never thought we could do business by ourselves. Or that we could earn." ***– Girls' Collective member, Namarchar***

Many girls attribute this change in their dreams to their participation in the IMAGINE intervention. They make a clear distinction between what felt possible to them before the program and after.

"I know the importance of study but never thought of doing a job and earning money. Now I think about earning and helping my family financially." ***– Married girl without child, Polashbari***
I: How has your thinking changed over time?
R: *"As I learned about women's health and the importance of being self-dependent from the IMAGINE project and my Kishori club, they helped me understand my goals and plan for a better future."*

"First and foremost, I want my business to be stable, as per my plan. I intend to educate my child and provide him with a bright future." ***– Married girl with child, Bosuniapara***
I: What factors contribute to the creation of a plan?
R: *"The IMAGINE project. I will change my life doing this business, and the project showed me how."*

Girls are participating actively in vocational activities

A number of married girls made a direct link between participation in vocational activities and an increase in their own agency or "self-reliance." Girls describe how delaying birth to pursue their education or work enabled them to communicate with their husbands, support themselves and their families and increase their confidence.

> *"The main problem with the women of our area is that they are very nervous. They lack confidence to do something on their own. Their husbands are not the same as mine. If they can earn something by themselves, they could be more confident, more assertive and self-dependent. Unmarried girls could bear their educational costs. Married women could support their families, children and themselves."* ***– Married girl with child, Jolapara***

This is echoed by others in the community who point to vocational training or education as a means of empowering girls. Here, again, IMAGINE is named as the source of this support/change.

> *"I think it would be better if the couple were delayed in childbirth and girls could earn more money for the family involved in the job. Hence, their future would be great. As a result, she will be self-reliant and independent. That's why I prefer and suggest delaying the first childbirth."* ***– Influential female, Jolapara***
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> *"IMAGINE project played an important role in creating awareness. Through the Kishori clubs, girls were inspired to do something by themselves and be self-reliant. We want more aware girls like that."* ***– Healthcare worker, Polashbari***

Girls' access to – and satisfaction – with SRHR is improving

Overall, girls and their husbands describe being able to access family planning methods (often from community health workers) and are satisfied with the services they receive. Several respondents describe how healthcare workers are friendlier and treat them with more respect than before. In a few cases, they also note that their satisfaction with health workers may be due to girls' own ability to articulate their needs.

> ***R:*** *"Yes, they [health workers] behave friendly with us and guide us properly about the family planning method. Mohideb project [staff][10] and community clinic officers gave us the same advice."*
> ***I: Did the health officers give good service and behave well earlier?***
> ***R:*** *"The village community clinic's health workers and officers didn't behave well before. We didn't feel satisfied with them back then."*
> ***R: They didn't give good service?***
> ***A:*** *"No [they didn't give good service in the past].[However], at present, they give their service well."* ***– Husband of married girl, Panthanpara***
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> *"[Healthcare workers] listen to us carefully and always suggest the best for our health."*
> ***I: Two or three years back, was their behavior the same as now?***
> ***R:*** *"No. There are some changes in their behavior. People were not aware of their health, so they could not explain their problems properly to the health workers. So, they could not treat well. Now we are aware and can explain properly, and they are giving us proper treatment."* ***– Married girl without child, Polashbari***

[10] The Mohideb Project is the implementing partner for the IMAGINE Project in this area.

➢ EQ3: Change in couples' ability to make SRH choices

NIGER

Couples are communicating about SRH

There are numerous indications from both girls and men in the community (husbands/Fada members) that communication between couples about fertility and SRH has increased. Not only are husbands and young wives having conversations, but also men are participating in things like family planning health visits. These changes in couples' communication and support around SRH are attributed to the IMAGINE intervention both explicitly (numerous s, noted above) and implicitly ("in the past two years").

> *"We have really had changes, because today it is the husband or the parents of the wife who encourage her to do family planning not only for the health of the mother but also the children. Today there are fewer births than before. People understand the importance of family planning and are applying it in almost all of its forms."* ***– Male Fada member, Dogo Maikassoua***
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> *"People don't have the same behavior as two years ago. We really had a big change. Before, they did not have the concept of family planning, but today, husbands understand that everything we are doing is to improve the living conditions of their wives and children. People are really convinced."* ***– Male Fada member, Djeda***

Girls themselves are reporting a notable change in husbands' participation in fertility issues and their own capacity to communicate with husbands around SRH and fertility issues. Several girls describe feeling confident to talk about these topics for the first time. They also are connecting the dots of the current IMAGINE work to future potential between young boys and girls to support and communicate with one another about SRH issues.

> *"In the past, men did not care how many children they want to have because for them, whatever the number, it is God who [decides]. But today, if their wives do not wish to have many children, they will support them."* ***– Girls' Collective focus group participant, Djeda***
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> "[*In the past] I didn't do anything [to prevent pregnancy]. I thought I couldn't talk to [my husband] about it. Now, things have changed. I can make decisions with him. Before, that was not possible, as I was too ashamed [to speak to him].* ***– Married adolescent girl, Tossoro***

These changes may have lasting effects beyond the intervention. As one Girls' Collective focus group participant describes, the work being put in to change community norms today will pave the way for today's boys and girls to become tomorrow's communicative married couples.

> *"Samira had the opportunity [to work] because she was able to delay her births. So, we too, with the sensitizations that are made to us and the young boys, will not have difficulty convincing them when we get married to them."* ***– Girls' Collective focus group participant, Djeda***

Husband's consent is paramount, for better or worse

As mentioned above, a husband's consent is a critical component in girls' ability to delay birth and pursue IGAs. A number of participants – girls and community members alike – cite the lack of a husband's consent as the sole barrier to either using family planning or engaging in activities outside of the home.

"As long as her husband has given his consent, there is no obstacle." ***– Married adolescent girl, Koleram***

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Q: What do you think of a married teenage daughter considering delaying her pregnancy?
A: *"I am completely in agreement with her doing it, but after first trying to obtain her husband's consent. This is the only guarantee that will allow her to be able to continue to do so. If they can agree on delaying the woman's pregnancy, then that's the goal."* ***– Male Fada member, Garin Galadima***

Husbands' control of girls' lives can impact their outcomes in both negative and positive ways. While a lack of a husband's consent to delaying birth or IGA may cut off a girl's ability to exercise her agency, his blessing to use family planning or engage in IGAs may be a protection against harmful community norms. A number of participants noted that as long as a married girl has her husband's consent for a girl to delay birth or work outside the home, then no one else in the community can impede her from proceeding with her plans. These findings echo the formative research from three years prior, indicating that there may be more explicit work to do around the issue of gender equity and girls' agency.

"As long as the husband has accepted, the family cannot prevent the wife from delaying pregnancy. Me personally, as long as my husband gives me permission to delay my pregnancy to save my health, the in-laws cannot stop me from doing it. I will pretend not to hear what the family is going to tell me." ***– Girls Collective focus group participant, Kaouga***

BANGLADESH

Girls and husbands report increased capacity to communicate
Girls describe better communication with their with husbands and other members of the community about childbirth and work. The example below illustrates a common trajectory, where increased awareness of the benefits of childbirth and access to vocational or educational training improved girls' ability to discuss these issues with those closest to them. Here, a married girl without a child describes how she first understood the dangers of early birth, and then how she transmitted that knowledge to their husband and mother-in-law to increase their support for her choices.

I: Can you discuss with your husband about when you want to conceive?
R: *"Yes. We got married at an early age and we have decided that we will delay childbirth."*

I: Why do you think you were able to discuss delaying childbirth with your husband?
R: *"I knew that he might come to me and say, 'Like other husbands, I need a child and you must conceive.' But I had the knowledge that I should get pregnant later. I explained, and then he understood."*

I: Have you discussed birth planning with anyone else in your family?
R: *"My mother-in-law. People ask my mother-in-law, 'Why isn't your daughter-in-law conceiving?' And she replies, 'She will when she comes to a proper age.' "* ***– Married girl without a child, Jolapara***

Other girls describe similar experiences where their ability to discuss issues of childbirth increased over time, leading to better support from their husbands or families to delay childbirth. Girls share the knowledge they have obtained about the dangers of early birth as a means of broaching the topic with their husbands, yet some acknowledge the need for a degree of persuasion and persistence on this point.

"*At first, I felt hesitant to talk about delaying childbirth. Now, we feel free to talk to each other. I share my thoughts; he shares his. We listen to each other.*" ***– Married girl w/o child, Kaim Gobindopur***

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"In terms of help, I have support from my husband and families. Maybe in the future I will need money for my further study or working. Then my husband and in-laws will support me. ***– Married girl w/o child, Polashbari***

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"At first, he might disapprove [delaying childbirth] or take it negatively. He will not support it. She has to persuade him gradually. She should not [approach him] right after he gets home from work, because he will be tired and agitated. When they are having a good time, she should talk about it. Even if that does not help, she should bring in someone whom her husband listens to." ***– Girls' Collective member, Trimohoni***

Three married girls spontaneously attributed the change in couples' communication to IMAGINE, and couples counseling activities in particular.

I: When you were newly married, could you talk about this issue with your husband?
R: *"No. At first, we weren't close and couldn't discuss many things. After some time, slowly we became friends, and then we could open up."*

I: How did this change come about?
R: *"He went to my father's place, and my family members persuaded him through a discussion. My brother and sister-in-law told him many things. After that, his thoughts changed."*

I: Other than that, were there any other things that changed his mind?
R: *"Yes. I did a session. Representatives from the IMAGINE Project arranged a counseling session with adolescent married women and their husbands. They told him, 'You should have the baby later. Your wife is not self-reliant.' That also helped him to change."* ***– Married girl with child, Jolapara***

For their part, husbands describe a mutuality in their support for married girls' desire to delay birth, and an improved capacity to communicate on the timing of children and use of family planning methods.

I: Do you discuss family planning methods with your wife?
R: *"Yes, we mutually decide which method we will adopt."* ***– Husband of adolescent girl, Pathanpara***

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I: Did you mutually decide to adopt the family planning method? Or did you alone decide that?
R: *"Yes, we decided that together. It's not possible to make a decision alone. We have planned to have a child two years later, and till then we will use a condom."* ***– Husband of adolescent girl, Jakuapara***

Couples tend to decide together, but husband's control is still a factor

Several husbands also pointed to the exclusivity of the couple in the decision-making process. Other family members may have opinions, but by and large, participants acknowledge that it is up to the couple itself to decide timing of childbirth.

> *"Husband and wife make most of the decisions about when to have a child. In my case, neighbors told me should have a child soon. But I ignored their opinion. My wife and I decided when to have a baby."* ***– Husband of married girl, Bosinupara***
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> *"If a young girl wants to conceive late, I think it is a good thing. … But if she requires suggestions and understanding, then I think the husband and wife need to discuss this issue together."* ***– Husband of married girl, Char Gopindopur***

However, in a few cases, there is still the specter of a husband's consent over fertility decisions that may limit couples' ability to come to a truly joint decision about delaying birth. On the other hand, once a husband has voiced support for a married girl, the decision is protected from outside influence (even mothers-in-law).

> *"The man has more right to make a decision. If the man says to conceive later, then that's the decision. And if the man says to have a baby now, then even if the wife doesn't want to, she doesn't have the power to say anything. After marriage, the girl has to do whatever she has been told to do."* ***– Husband of married girl, Jolapara***
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> *"Sister, listen. If her husband supports her and listens to all she says, then what the neighbors and outsiders say or don't say is not a matter of consideration."* ***– Girls' Collective member, Jolapara***

➢ EQ4: Changes in healthcare workers' capacity and behavior

NIGER

Healthcare workers feel capable and empowered to serve and advocate for girls

Healthcare workers note an increase in their capacity and feelings of empowerment to support the girls and the communities in delaying birth and accessing family planning. They report improved professional skills in providing care to young girls, particularly around how to speak to them and sensitize them on SRH.

> *"The change that I noticed is that before the trainings I didn't have a good method of approaching clients so that I could sensitize them. But since the training, I know what to say to them to get their attention."* ***– Healthcare worker, Lingui***
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> *"It has strengthened our capacity, because before, we could not sensitize these young girls. The only thing we could do when they got pregnant is look at them, without knowing what we could do for them. But thanks to the training, we are committed to explaining to them how to rest before thinking of having children and also how to look after themselves and take care of their children."* ***– Healthcare worker, Koleram***

This change in capacity, in turn, increases healthcare workers' motivation to provide SRH care to married girls and to engage in training and sensitization of the community. Participants attribute this change in healthcare workers' behavior, attitudes and commitment to the IMAGINE project trainings.

> *"I am delighted to have taken part in these trainings, because they have strengthened our working capacity. We were told that when a woman wants to use contraceptives, we do not have to wait for her husband's permission. We are covered by the law. This is why since training I have been doing family planning more than curative care."* ***– Healthcare worker, Gojo Gojo***
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> ***I: Have you noticed any change in the attitudes and beliefs of healthcare providers regarding adolescent rights?***
> ***R:*** *"There is a clear change. During our monthly meetings, we discuss a lot of subjects regarding contraceptives and behavior change. Really, we noticed a lot of change."* ***– Healthcare worker, Dogo***

Furthermore, the IMAGINE project training has changed health workers' view of their roles – from being there simply to provide healthcare services to being advocates for girls' rights and choice. Healthcare workers describe an awakening of their responsibility to raise awareness around girls' reproductive health and to promote delaying early birth among married girls.

> *"The IMAGINE project took care of us and was quite sensitive to us. The training has increased my determination and skills [to defend the rights of young married girls]. In the past, I didn't know a lot of things in this area."* ***– Healthcare worker, Dan Makao***
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> *"The [role of a provider] is to keep [adolescent girls] happy. We can make her aware so that she knows that before anything else, it is her own health that is at stake and that those who criticize her cannot help in the event of a complication."* ***— Healthcare worker, Kalgo Tchama***

Healthcare workers note community shifts

As gatekeepers to the healthcare system, health workers are well-positioned to track changes in overall shifts in community attitudes and behaviors around married girls' SRH support or participation. From their point of view, there has been a marked increase both in support for girls' use of family planning and girls' actual accessing of contraceptive methods. Again, these advances are directly attributed to the IMAGINE/CARE intervention.

> *"There is a clear change, especially with the arrival of Imagine NAZARI*[11]*. There is an increase in the number of adolescent girls who come to take contraceptive products thanks to the monthly meetings and the sensitizations carried out by the community relays. For example, before, we might have five or 10 girls who come to take contraceptive products, but now we can have 15 or 20 per month, so you see there is a clear progression. And this progression is due to these meetings with the relays and especially the agent of IMAGINE NAZARI."* ***– Healthcare worker, Dogo***
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> *"Now, parents know there is no benefit to early marriage. They now insist that girls practice family planning."* ***– Healthcare worker, Gojo Gojo***

[11] NAZARI is the name of the IMAGINE project in the Houssa language which is spoken in Niger

BANGLADESH

Healthcare workers feel more connected, more capable

Healthcare workers report feeling more capable in their jobs and able to communicate more effectively with adolescent girls about family planning and delaying birth. Due to their IMAGINE training, they report increasing their efficiency as well as improving their rapport with their clients, particularly girls. Through new communication techniques and technologies, healthcare workers also are able to reach remote clients more effectively.

> *"There is much improvement in service [because of] different types of training. We have been taught how to maintain privacy of the service recipients, how to behave well and greet them warmly. … There has been a change in behavior both for us and the recipients."* ***– Family welfare assistant, Kurigram***
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> *"We are working more efficiently than before. We are trying hard to reach every corner of the village. There shouldn't be any couple left out. We are connecting with everyone. Our communication with clients is much better than before – we contact them through mobile phone. People are much more interested in receiving our service nowadays."* ***– Family welfare assistant, Jolapara***

Healthcare workers also note a greater sense of connection to the work and sense of purpose to deliver services in their communities. This is due not only to increased skills and training at the individual-level but greater capacity and comradery at the collective HCW level.

> *"Imagine Project gave us the training to increase our knowledge and efficiency. There we realized that it's not enough to work alone. We should work together. We should behave friendly and grow an excellent relationship with clients. We learned how to think positively to improve our service."* ***– Family welfare assistant, Jolapara***
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> *"The training that IMAGINE project provided was helpful for us too. It makes things easy, easy to provide services. Though we have workers who convince at the field level (in the community), it becomes easy. Maybe one's word wouldn't work, but when ten people (many people) say the same, it would work, become successful. That's why."* ***– Healthcare worker, Jolapara***

Healthcare workers note positive changes among girls

Healthcare workers also reported perceived changes around delaying birth and method use in their communities. In the past, married girls were more fearful or shy about the topic of family planning, and often were discouraged by family or community members from using any methods. Through healthcare workers' counseling and IMAGINE project efforts, providers are noticing a change in girls' knowledge and desire to use modern methods.

> ***I: How was it before, and how is it now?***
> ***R: "****[Girls] were afraid to use a condom or contraceptive pills. They thought they wouldn't conceive later if they used any contraceptive method. Their in-laws and other older people convinced them not to use contraceptives. After our repeated counseling, some of them realized they could use condoms and still have a baby later."* ***— Family welfare assistant, Jolapara***
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"Now women know when to use contraceptives after childbirth. People didn't know anything about this [several years ago] and often conceived two months after the birth of a child. Now it doesn't happen." ***– Family welfare assistant, Kurigram***

Healthcare workers describe a new "vibrancy" among adolescent girls, and a deeper capacity on their part to speak up for their SRHR needs.

"When Imagine Project was there, adolescent girls of the 'adolescent (Kishori) club' were very aware and active. There was a different vibrancy among adolescent girls. I mean, here if they (the project) is not here then things will revert to its previous situation. If nobody supports them." ***– Healthcare worker, Polashbari***

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"We didn't talk in that way before. They felt ashamed. If we [discussed certain topics,] they would stop coming here. Now they don't feel ashamed. They sit and listen to us carefully. They feel comfortable talking about these issues. They ask, 'Madam, what would happen if we took this?' Now they talk face-to-face with us." ***– Healthcare worker, Kurigram***

Lingering method misconceptions/biases may limit girls' access to SRHR

Despite these advances, healthcare providers in the IMAGINE intervention areas still harbor some myths and misconceptions around hormonal contraceptive methods that may impede girls' full access to and choice of preferred method. Three different healthcare workers said they wouldn't provide injectables, implants or intrauterine devices to girls who have not yet had at least one child. In at least one of these cases, the health worker openly acknowledged her bias as the cause, while the other two appear to believe in the misconception of infertility due to hormonal methods.

"We have some of our beliefs that remained unchanged. We instill that belief in them while giving services. Such as, we still don't give injections or implants to those who don't have any child. We often give advice based on our own preferences. I won't deny that." ***– Healthcare worker, Polashbari***

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"Family members and the in-laws can pressure them not to use any contraceptive method. But nowadays, girls know about this before their marriage, so they come to us despite the family pressure. Then we first suggest a condom. If her husband refuses to use it, then we recommend oral pills. We don't suggest injectables in such a case, because it can cause infertility later." ***– Family welfare assistant Kurigram***

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I: Many adolescent married girls come to you for family planning services. Is there any method that you think isn't applicable for them or that can harm them in any way?
R: *"Injectables can't be given to adolescent girls. After that, copper T shouldn't be given."*

I: What problems can occur if you give those to girls?
R: *"Those methods can cause infertility later."* ***– Family planning visitor, Kurigram***

Healthcare workers also mentioned an open bias against providing SRHR to unmarried adolescents due to a moralistic stance against premarital sex or a disbelief that unmarried girls would need SRHR.

Case Studies in Complexity

We developed a series of case studies both with girls who delayed birth during the program years and girls who experienced a birth in this same time period in Niger.[12] By linking girls' interviews with that of their husbands and another influential adult in their lives (identified by the girls), we aimed to bring context and richness to the complexities around delaying birth and pursuing IGAs. The three case studies depict a spectrum of support for delaying birth and pursuing income-generating activities that highlight the multifaceted nature of SRH decision-making in these communities and discourage simplistic attempts to put forth binary conclusions associated with the success of the project. These case studies have been organized along a continuum, ranging from a family with clear-cut intentions to support delaying childbirth to those with more conservative, religious concerns that may undercut attempts to protect girls' lives and livelihoods. They also depict a range of attitudes and behaviors along the areas of interest in this evaluation – namely, girls' agency and ability to delay, couples' communication around SRH, and general attitudes toward delaying birth.

➢ **CASE STUDY 1: Proactive Planners**

Maiumouna is a 17-year-old married adolescent girl with no children. She lives with her husband in a village in the commune of Dogo, not far from her parents and other family members. She's been married for about a year and is using a contraceptive method to delay her first birth. Maiumouna has the support of her husband and father, and feels very strongly that delaying a first birth is a positive decision both for girls and their families. She notices a change in her community, with more and more people – particularly husbands – supporting delayed first birth among married girls. Thanks to awareness-raising efforts at the community level, delaying birth is becoming more normalized, and girls like Maiumouna are considered serious and intelligent. She has the courage to talk to her husband about family planning and also seeks the advice of her aunt for decision-making. In the next 10 years, Maiumouna wishes to have two children.

> *"People will appreciate [Samira's] strategy [to delay birth in order to work] and consider her a serious and intelligent woman." –* ***Maiumouna***

Maiumouna's husband, Soufianou, is 25-30 years old (he's unsure) and works as a gardener. He is a big supporter of using contraceptive methods to delay pregnancy and sees a lot of families in his village with working wives and fewer children than before. He thinks delaying birth is an "evolved" way of being, and considers those against it to be religious conservatives. He estimates that over the past two years, husbands' support for wives to work has increased from four out of 10 men to seven out of 10. All this is thanks to the sensitization projects in the village. He accompanies his wife to the health center for her SRH visits and wanted her to delay pregnancy because she was too young when they first got married. He gives his full support to this shift in local norms, but does make it clear that the husband decides when and if pregnancies are delayed.

> *"There are people who think that if the woman is using contraceptives, it is as if she has killed a child. According to them, religion does not allow the use of contraceptive methods. But I think a man can organize his family and have children according to his means. It has no downsides."* ***– Maiumouna's husband***

Maiumouna's father, Mallam, is a 55-year-old farmer with three wives and 17 children. He is an adamant supporter of delaying birth among young married girls and believes girls should not have their first child before age 20. Of course, he adds, husbands have the final say in what happens to a girl once she's married, but parents should play a role in

> *"We think couples are doing the right thing [by delaying]. Consequently, we support them 100%. And it is the awakening of consciousness that is the source."* ***– Maiumouna's father***

[12] Data from Bangladesh were not rich enough for distinctive case studies.

protecting their daughter by ensuring she is fit and mature before she is married. Mallam remembers that in his day, many women suffered from early or closely spaced births, leading to a lot of suffering and poor health. He sees so much change in his village around supporting women to delay birth and run their own businesses. For Mallam, this is a result of an awakening of consciousness thanks to projects like IMAGINE. Continued support from these types of projects will help his community fight poverty. The key, according to Mallam, is to participate in group activities to avoid being ignorant and blocking progress.

➢ **CASE STUDY 2: Passive Supporters with Lack of Communication**

Amina is a recently married 15-year-old girl who lives in a village in the commune of Dogo. She has no children and hopes to one day open her own clothing boutique. She is not using contraception and thinks that because she is young, healthcare workers would not believe she's married and reject her SRH requests. She has shared her family planning desires with her husband, but she thinks he prefers she wait to take contraceptives until after giving birth to her first child. She can't do anything without his consent. In Amina's mind, a "successful" couple is one where the husband and wife agree to use contraception. However, as far as the rest of the community goes, some people support delaying and some people don't. According to Amina, there are still those who will consider a girl who delays birth to be barren, and will not stop insulting her until she has a child. Mothers-in-law can be the biggest culprits in this sense. That being said, Amina doesn't think that pregnancy necessarily impedes a woman's participation in income-generating activities, as long as her hijab hides her belly.

> *"There are couples where delaying childbirth has improved, and others where it has not. Everything depends on the life of the couple."* ***- Amina***

Amina's husband, Hussein, is 24 and unemployed. He sees many benefits to delaying birth – above all, to avoid birth complications and protect the health of the mother. Hussein and Amina haven't really discussed the timing of their first child, but he is open to her using a contraceptive and is willing to discuss it. In the past, people might have thought that a woman who delays birth is running around on her husband. Nowadays, so many people are on contraceptives in the village, Hussein doesn't think delaying childbirth would pose a problem for him and his wife. Furthermore, Hussein is supportive of his wife's desire to work, because it will make her happy. He's aware of the sensitization programs taking place in his community and credits them with the changes in attitudes toward delaying birth.

> *"If she wants [to work], I'll be OK; and that is to make her feel happiness, and that she feels loved. It is for the best."* ***– Amina's husband***

Amina's mother, Zoulaye, is 30 and has seven children. She believes that young girls should take contraceptives to avoid having problems during childbirth. She says that nowadays husbands and wives make family planning decisions together, which never used to happen. But this issue is not without contradictions and tensions in her village, she says. Zoulaye advises her own daughter to use contraceptives and thinks her daughter's pursuit of IGAs would be very positive. On the other hand, she believes such a girl may be considered barren or a bad wife by community members. Just like her daughter, Zoulaye thinks that people will have varying opinions on the topic, but ultimately it is up to the husband to decide.

> *"People's opinions differ on this issue. Others will talk about taking contraception, and others think it was God who did not give the young woman. Her husband can help her if she wants contraception. … It's her husband who is the center of everything."* ***– Amina's mother***

➢ **CASE STUDY 3: Naïve About Family Planning and Under Family Pressure**

At age 16, Yasmina has been married for two years and is expecting her first child soon. She felt that after two years of being married she had to become pregnant or else people in her village in Kolleram commune would ridicule her or accuse her of being barren. At the time of conception, Yasmina didn't know anything about contraceptives or SRH; she was barely literate. Besides, she was too ashamed to speak to her husband about such things, as they were strangers to each other then. Now, she feels like she can speak to her husband about these issues, and she wants to use the injection to space future births even though she's afraid of needles. Yasmina sees how more and more married girls in her village have opportunities to work now, and she thinks that's a good thing. But she doesn't think that delaying birth in order to work is a good idea – a woman can work while weaning a child, she says. She is training in cowpea processing and has noticed a change in her ability to make decisions for herself. Though Yasmina has noticed that support for girls' working has increased in recent years, there always will be people who disagree. As long as her husband approves, she is happy.

> *"I was two years married before giving birth to this child. At two years, what else can you do? We risk hearing criticisms that such a person [who has not given birth] is sick or barren."* ***- Yasmina***

Yasmina's husband, Malam, is 21 and works as a moto taxi driver. He personally doesn't have a problem with delaying birth but recognizes that in his community a lot of people are against it. Where they live, a girl has to get pregnant in the first year or two or people will think there's something wrong with her. Malam thinks that delaying and spacing births are good for the woman's health and is actively discussing spacing with his wife. He accompanied Yasmina to the health center, where he was welcomed warmly by the service provider and learned all about different contraceptive methods. Malam and Yasmina already have decided to wait five years before having their second child so they can better organize their lives. Malam thinks Yasmina's participation in IGAs is a good thing for the family, and admits that when she first got pregnant, he didn't know about family planning methods. Malam sees that people in the village are more aware now and support women to pursue work outside the home – that is, of course, with the consent of her husband.

> *"Women are being educated about the benefits of birth spacing, pregnancy delay and early marriage. Because I let you already said, if a woman is not mature she will encounter health problems without during childbirth."* ***– Yasmina's husband***

Yasmina's mother, Mariama, is 48 and the mother of eight. She believes that as long as a girl is 17, she can start having children – there are no down sides. It doesn't matter if the girl is in school or working at the time; she can handle both her outside life and having a child. In Mariama's opinion, a married girl has no say in when she gets pregnant – it's all up to the husband to decide. As long as parents wait until the girl is the right age to marry, then it doesn't matter when she gets pregnant. She can space births later, Mariama says.

> *"Frankly, a woman should not delay her pregnancy for the sake of economic activity. Unless the woman has a problem with childbirth, people in the community will think it's not a good thing."* ***– Yasmina's mother***

Conclusions

- **There has been a change in support for delaying childbirth and IGAs, and it's thanks to IMAGINE.**

Without a doubt, there has been a change in the way people in these communities consider and support delaying birth. Numerous participants, from girls to husbands to community members, not only express support for delaying birth, but they also note changes in acceptance in use of modern contraceptive methods. Healthcare workers in particular note a shift both in community norms for girls using methods to delay as well as in raw figures of SRH service attendance and method uptake. Through the multi-pronged IMAGINE approach, more people across population segments in the community are discussing delaying and method use than ever before. Nearly everyone agrees that it is essential to ensure that a girl is of a mature enough age (typically 17 and older) before her first birth to avoid complications such as fistula. However, *delaying* birth still is not as normalized in these communities as birth *spacing*. There is no wavering among respondents that spacing is important for the health of the mother, child and family; but delaying birth still comes with the stigma of interfertility for the girl or her husband, and this stigma may be creating pressure to give birth even if the couple themselves would rather delay.

When it comes to IGAs, there seems to be almost unanimous support for girls' participation. In both direct description of attitudes and behaviors, and through the use of the "Samira" vignette, participants expressed encouragement for girls' working. Several participants also drew comparisons to the recent past, explaining that whereas previously girls working outside the home would be considered troublemakers, now they are considered helpful and intelligent. While support for IGAs is high in this population, respondents were clear that working outside the home is not a good enough reason to delay birth. In fact, several participants remarked that girls who delayed birth in order to work would be perceived negatively in the community.

Using the QUIP approach, which solicits unbiased and spontaneous connections between observed changes and the sources of that change, participants credit "sensitization" and "training" activities with the awakening around delayed birth and IGAs. Without prompting, a number of participants directly named CARE or IMAGINE as the source of this positive change.

- **The future for girls feels bright, but barriers remain.**

Both married and unmarried adolescent girls in these communities are able to imagine lives beyond rote childbearing – something that was barely present in the formative research that took place in these same communities just a few years ago. Girls describe having more knowledge of work opportunities, more education on family planning methods and more agency to discuss fertility with their husbands and make decisions in their own lives. These richer lives include work opportunities, ownership of businesses, education and participation in activities like IMAGINE.

In Niger, the arrival of IGAs has not supplanted the desire to become mothers; nor does it seem to be a compelling justification for delay for most. Instead, girls are able to envision a life where they can have both a viable business and a healthy family (the connection between them being implicit in most cases). Girls speak openly about growing their opportunities outside the home and blending work with a life with babies. The only burden of childbearing is related to closely spaced or overly numerous births; a number of girls in these communities expressed wanting no more than two or three children over the next 10 years, a feat in a context where the latest fertility estimations are more than double that. In Bangladesh, girls and their families are enthusiastic about delaying childbirth in favor of IGAs and envision work as a means of improving their economic stability. Unlike in Niger, there is a recognition in Bangladesh that early childbearing can interrupt girls' educational or economic advancement, and the preference is to delay.

Girls also feel more confident and capable around SRH services. They notice and appreciate the way in which healthcare workers treat girls now, and those who have gone to facilities for family planning are

satisfied with the services. A small number of girls mentioned healthcare workers who required a husband's approval or verification to provide contraceptives.

Despite this progress, girls still perceive a stigma around delaying birth. They speak of Samira's behavior as aspirational, but concede that such a girl could still face resistance from her family, husband or community members when desiring to delay or work. In particular, girls are concerned with the specter of perceived or actual infertility, and some would prefer to have a first child before using any modern methods, just to be sure. These beliefs point to continued negative norms around delaying birth, as well as the presence of myths and misconceptions of the side effects of hormonal contraceptives, which even some health workers in Bangladesh continued to voice. In Bangladesh, in particular, having a child is still discussed as a way to cement and demonstrate commitment to a marriage. Despite this, there appears to be a growing sense that this view, and others that stigmatize couples who delay, is starting to be left behind. Those who criticize or gossip about couples who do not have their first child soon after marriage often are described as older, less educated, or having a negative mindset. What is more, community members also expressed the importance of adolescent girls as "good human beings," perhaps signaling the acceptance of the value of her identity separate and distinct from wife and mother.

- **Couples are communicating, but girls' agency is low.**

The intervention appears to have increased couples' ability to discuss their fertility openly and make decisions together. Husbands express support for their wives' delaying birth to preserve their health and appreciate the notion of their contributions to the household through IGAs. Men themselves describe how husbands are more open to communicating about family planning, and several recounted joining their wives on visits to access SRH services. For their part, girls also mention being more able to speak with their spouses about fertility – a notable change from just a few years ago.

Though husbands' support for delaying and IGAs is on the rise, husbands still have the final – and sometimes only – say on what happens with the couples' fertility. A married girl must have his consent to delay or space using a method, and must equally clear any pursuits outside the household with him. There is a distinct undercurrent of gender imbalance in household decision-making, and it is a widely recognized feature of households in these communities. In fact, a husband's control over a girl's life is so absolute, that once he makes a decision about childbirth or work (one way or the other), no one can override it, not even other family members such as mothers-in-law. So, while girls' and young couples may be more comfortable discussing some of these topics, girls' independent decision-making and autonomy remain severely limited in important matters related to their own health or economic participation.

- **Healthcare workers benefited greatly, but material concerns and misconceptions remain.**

Healthcare workers present the clearest case for success in the IMAGINE intervention. Interview participants describe an increase in their knowledge and capacity to provide SRH services to girls, and they attribute this change directly to the IMAGINE intervention. These workers recount feeling more empowered and motivated in their jobs, and several describe seeing themselves as advocates for girls' health above all else. Alongside this progress, supply chain issues and cost of commodities still create significant barriers to girls' ability to access timely family planning services. In Bangladesh, healthcare workers continue to have misconceptions about the effects of contraception on fertility and a bias against unmarried girls.

- **'Early birth' is an arbitrary target.**

In this project, the concept of delaying birth often was loosely defined as within two years of marriage for an adolescent girl and/or not before she reaches age 18, and we see many respondents sharing this benchmark during data collection. However, given that age at first marriage may range from 14 to as high as 20, future programming may benefit from deeper clarification as to the safe "age" at first birth and how that relates to girls' early marriage, gender equity and reproductive rights and choice overall.

KEY DIFFERENCES BETWEEN NIGER AND BANGLADESH

In both country contexts, we see notable improvements in attitudes and behaviors toward girls' delaying birth and pursuing alternative futures. However, in Bangladesh, there seems to be a greater emphasis and acceptance of girls' delaying first birth in order to participate in incoming-earning activities than in Niger. This may be attributable to cultural and developmental differences between the two contexts. First, there is a much stronger influence of religion on the birthing experience in Niger. Girls and their families explicitly mention God's will as an important element in the timing of birth, and have a more fatalistic attitude toward childbearing than what is observed in Bangladesh. Furthermore, in Niger, we see more frequent spontaneous mention of "health" as a motivating factor for delaying birth, while in Bangladesh, participants tended to emphasize income generation as a primary motivation in delay. This may be due to the fact that Bangladesh, as a whole, is further ahead in the maternal mortality reduction curve than Niger, so the specter of maternal death is less present and therefore less relevant than in Niger. Finally, based solely on the demographics of the study population, we see that 60% of married girls with children and 33% of those without children in Niger already are engaged in some type of income-earning work, while in Bangladesh those figures are 9% and 0%, respectively, which also may impact the prioritization of work over health in Bangladesh.

Where Are We on the Spectrum of Norm Change?

There have been advances in many areas that are antecedents to full behavior change, but there is still work to be done. It is important to understand that social norms and behaviors change along a continuum and that the significant shifts we see through the results of this evaluation indicate that the change process is process, we are moving toward the more equitable end of that continuum. To better assess the spectrum of norm change resulting from the IMAGINE intervention, we can look to CARE's SNAP Framework and the Social Norms Learning Collaborative to gauge progress in Niger and Bangladesh.

According to the Social Norms Learning Collaborative, there are three main signs that social norms are beginning to shift:

1. People believe it is becoming more common to act outside of the norm.
2. People think there is less of a backlash against and/or more support associated with acting outside the norm.
3. There is no longer consensus in the community about the norm.

In both country contexts, we see reports of more and more girls delaying birth and engaging in IGAs than before; we see more support for family planning use among married girls; and we see more general support for this behavior in the community. Though there still are those who do not support the shift, there no longer is a clear consensus in norms around delaying birth and IGAs.

CARE's SNAP framework offers more insight into the shifting norms. Figure 1 (below) explains the five main components of norms along which we can measure change. Using the vignette of Samira, we see that more and more girls and members of their communities approve of the type of behavior that Samira engages in. There is nonconformity in people's judgments of Samira delaying birth and engaging in IGAs, and the trend is moving more and more toward approval. Furthermore, though sanctions for delaying birth (i.e. the negative consequences for not respecting a social norm) are still present in the community, they are not uniform across the population, and sensitivity to sanction is decreasing (i.e the negative consequences are easier to overcome or hold less weight than previously), particularly when husbands and girls present a united front. Girls and their husbands discuss desiring their own path forward in fertility planning, and community members respect couples' sovereignty in decision-making.

Notably, the majority of respondents name key exceptions under which girls would be permitted to shift their norms around early birth: 1) to protect herself and her child's health; 2) to improve the financial stability of the family; and 3) if the husband approves of her behavior. In the context of this framework, a husband's consent becomes the prevailing exception by which girls can shift their norms around timing of birth and participating in activities outside of the home.

Per these frameworks, we can conclude that there are clear changes taking place in intervention communities around social norms for delaying early childbirth and girls' participation in IGAs. Social norms are the behavioral rules held by a group that direct behavior; thus, we can conclude that since the IMAGINE intervention is beginning to shift norms around delaying birth and IGAs for girls, significant behavior change may not be far behind.

Figure 1: Social Norms Analysis Plot with Signs of Change

COMPONENTS OF A NORM	DEFINITION	SIGNS OF CHANGES IN A SOCIAL NORM
Empirical Expectations (EE)	What I think others do	• Responses reflect a different perception of what people think others are doing • Increase in respondents report a perceived change of behavior of others • Changes in the extent of conformity and disagreement among homogenous groups, and across the different groups
Normative Expectations (NE)	What I think others expect me to do (what I should do according to others)	• Responses reflect a different perception of what others expect respondents to do • Increase in respondents reporting the desired new behavior as expected of them • Changes in the extent of conformity and disagreement among homogenous groups, and across different groups • Changes in alignment between empirical and normative expectations
Sanctions	Anticipated opinion or reaction of others (to the behavior) – specifically others whose opinions matter to me	• Changes in sanctions that are identified • Changes in the severity of sanction • Changes in the likelihood of sanctions being enacted • Changes in consistency across groups
Sensitivity to sanctions	Do sanctions matter for behavior? If there is a negative reaction from others (negative sanction), would the main character change their behavior in the future?	• Changes in how the main character would respond to negative sanctions • Increase in respondents who say the main character would still behave in the desired way despite sanctions
Exceptions	Under what circumstances would it be okay for the main character to break the norm (by acting positively)?	• Change in the # of exceptions allowed to break a norm • Changes in # or types of individuals who deviate from the norm • Changes in responses about individuals who are impervious to social sanctions

Recommendations

The findings from the IMAGINE qualitative evaluation offer a few key recommendations to consider for future iterations of the program.

- **Continue programming in these communities**. The program, despite numerous interruptions and difficulties in implementation during the pandemic, has made a difference in nearly all the original

areas envisioned by the theory of change. Shifts of this kind, with behaviors as ingrained and integral to cultural identity as childbirth, are tricky to accomplish under any circumstance. The fact that we are seeing signs of meaningful change in social norms around married girls' lives in less than three years of intervention suggests that the IMAGINE project is having an impact. Though this qualitative research was not able to tease out the specific program pathways that led to this change (perhaps a job better left to triangulation with the quantitative survey), it does demonstrate that as a package of interventions, IMAGINE is accomplishing its objectives.

- **Examine lessons from spacing work and apply here.** Though the shifts in norms around delaying birth are nascent and still somewhat fraught, there is unanimous support for spacing births in these communities – something that was not present even a decade ago. This indicates that norm change around a topic that is sensitive, subject to social stigma and entrenched in cultural and religious context is possible. We suggest using the advances in norms and behaviors around birth spacing as a roadmap for continued progress with delaying birth. We already see that community members liken delaying to spacing when it comes to protecting girls' health; this point may be leveraged to further ingrain a positive social norm around delaying early births for girls. There is a robust field of research and program lessons around healthy timing and spacing of births that may be useful here, as well as lessons from local programs that work on encouraging birth spacing. This is particularly relevant to the population in Niger, more so than Bangladesh.
- **Do more stigma work/values clarification.** While support for delaying birth is increasing in these communities, we still see signs of stigma around infertility and myths/misconceptions of side effects of contraceptive methods. Additional work may be necessary at both individual or community levels. Furthermore, the case studies show that even within the same family unit there may be varying opinions or misunderstandings around delaying birth. More work on effective sharing/communication about real norm shifts that are happening in these communities, particularly if they continue and reach a threshold of pluralistic ignorance, may empower girls and their husbands to make healthful choices around birth timing and accelerate positive norm shifts around delaying birth. A start would certainly be sharing these findings with communities!
- **Focus on gender equity to increase agency.** An important undercurrent of this work is the lack of gender equity and agency for girls in these communities, even after these interventions. They are beholden in almost every way to their husbands when it comes to family planning or IGA decision-making. We do see some advances in girls' own sense of self as well as increased communication among couples, which could be early signs of improving gender norms. A continued focus on gender equity and increased agency also would allow communities to build on their growing acceptance of admittedly arbitrary thresholds around early marriage and birth – there is nothing magic about 18 years of age or two years of delay – and instead create environments where girls are able to make their own choices regardless of "standards" or accepted milestones.
- **Value improving girls' ability to engage in the workforce and in markets beyond the impact on their reproductive lives.** It is clear in both contexts that girls valued and appreciated the opportunities that learning a vocational skill and engaging in income-generating activities offers, but in Niger in particular, this did not seem to be the motivator to delay first birth that the project originally hypothesized. This does not mean that advances in girls' economic empowerment should not be valued; rather, if we seek to impact their health, their reproductive autonomy and bodily integrity, we need to also continue to invest in norms change and agency building.

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