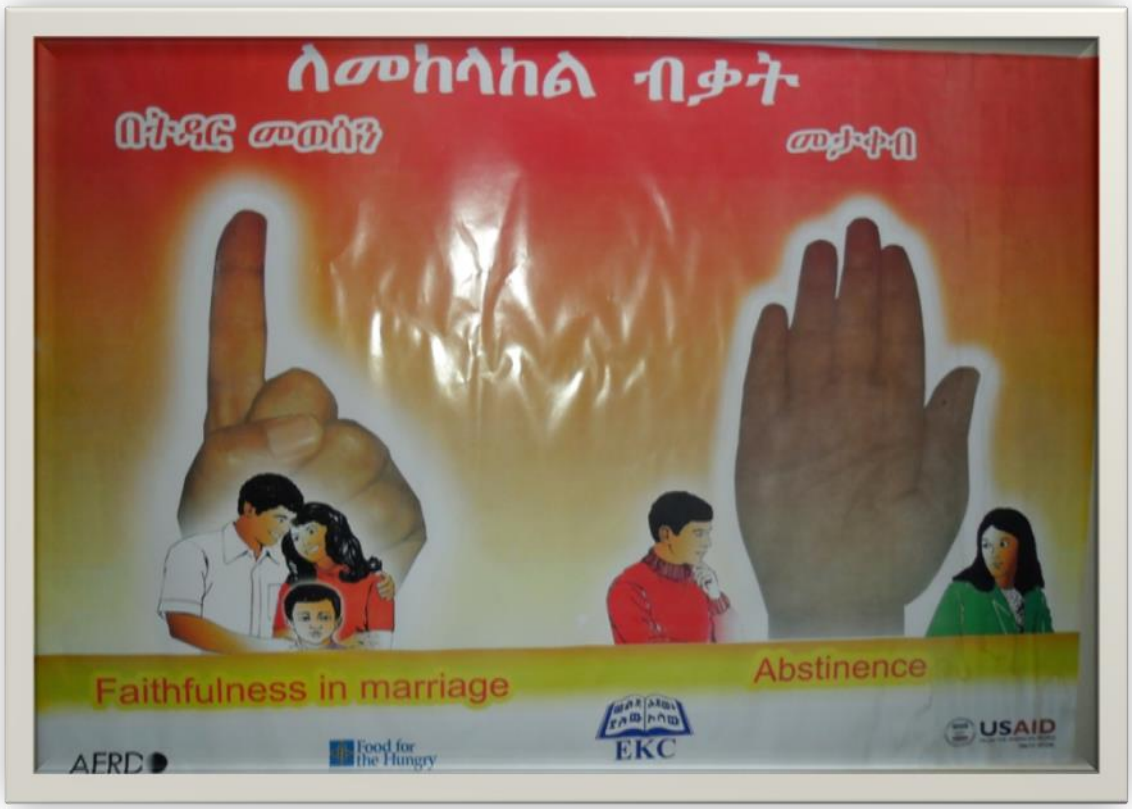
Family Planning choices within marriage and before

Practices, perspectives and potentials in faith-based Family Planning programs in DR Congo, Ethiopia and Malawi



Enablement Associates:
Marije Cornielje
Geertje Dingemanse-de Wit
Wilma Smilde
Johan Velema

July 2014

Research Commissioned by coPrisma and the ICCO Alliance

Executive Summary

In this qualitative research we aimed to document *perspectives* and *practices* of faith-based partner organisations in Ethiopia, DR Congo and Malawi on how they support their beneficiaries in taking informed and voluntary decisions related to family planning (FP) and provide access to pregnancy prevention methods (PPM). In addition, we sought to identify potentials or learnings from programs that are functioning well resulting in our recommendations for further program development. Our specific focus within this research was on youth as they have specific needs and have to overcome specific barriers in regards to accessing PPM and information.

We point out that in order to understand and verify the perspectives and practices of partner organisations it was necessary to take into account the point of view of community members, as well as keeping in mind the specific social, cultural and/or religious context in which it all takes place. We specifically asked what influence religious beliefs have on the acceptance of PPM. Therefore we did not only speak with staff members of the FP programs, but also interviewed clients, community members, community leaders, and religious leaders.

Practices of partner organisations

Our first research question was: *What are the practices of partner organisations on voluntary and informed decision making regarding family planning and access to pregnancy prevention methods?* In response, we looked at the availability, the quality and the accessibility of services.

We found first of all that, in terms of **availability of services**, the different partner organisations each have their own focus. While some provide PPM as part of basic health services, others focus on safe motherhood, while still others aim for HIV prevention. We found that the staff working in FP programmes do not always have correct and full knowledge of FP themes.

The promotion of FP is not only through the FP programs themselves. Media, families and churches each have an important role. Unmarried people obtain information from other sources than married people (e.g. peers, youth groups, school) and it is good to take this into account.

The goal of counselling in the different places was to give information about FP options to clients. Privacy (as stressed by Engender Health) was however not always ensured as the settings where counselling takes place were sometimes very basic. Privacy might however be less of an issue then Europeans might hold. In the case of rural Malawi mobile outreach services were often social meeting places at the same time.

Availability of PPM was different for each partner organisation, often due to the different types of health facilities the partner organisations collaborated with. Condoms, pills and injectables were the methods most easy to obtain and together with implants most often used.

In terms of the **quality of services** we looked at knowledge of staff and social qualities. For both we recommend (follow-up) training. Not all the staff working in FP had been trained on FP. Knowledge of staff about methods is not always complete and even insufficient in terms of side-effects. As such, some staff feel insecure when it comes to providing FP services. Furthermore, we found that not all

clinics can offer implants as it is necessary to have trained staff to do this. As regards the attitude of staff, we only received positive feedback from the community.

Counselling is important for the quality of services. As such, counselling is in many places a prerequisite for accessing further FP services. It was encouraged in several places, or even obliged, that women bring their husbands to counselling sessions. On the one hand this might create a barrier for women to access FP services, while on the other hand it increases male involvement and therefore might increase couples' dialogue on FP. Time pressure was sometimes an issue for staff and clients and, in addition, in Ethiopia staff sometimes had very outspoken ideas about what is the right type of method.

Accessibility of services was sometimes hampered by a number of barriers, such as: unclear prices, lack of privacy, service requirements, transport (or distance), and lack of education on the part of clients. Furthermore, vulnerable groups face even stronger and additional barriers to accessing FP services. The societal norm for unmarried youth is to practice abstinence. Besides youth's reluctance to be seen to use FP services, staff sometimes hesitate to provide PPM. In DR Congo, the law restricts the distribution of condoms to minors under 18 years of age. On the other hand, some partner organisations offer youth-friendly services and train staff to interact with youth. Accessibility to PPM (for youth) in Malawi is increased by community-based distributors. Additionally, we found that persons with disabilities, pygmies and sex workers had specific barriers to accessing FP services.

Different perspectives on family planning

Our second research question was: *What are the perspectives on voluntary and informed decision making regarding FP and access to contraceptives?* In order to answer this question we studied perspectives both of staff and of the community.

Community perspectives on the available FP services were generally positive. People mentioned an overall improvement since the FP services were introduced. Only rarely people were negative about FP services; sometimes from their own experience and sometimes from stories going around.

Staff in some places mentioned that they were short of materials, and/or that they encountered problems in terms of hygiene, time for counselling, mobility and travel expenses. While many staff are motivated and dedicated to their work, they could sometimes be better rewarded for their efforts.

Concerning community perspectives on FP, we clearly saw that these were affected by the social, economic, political, and religious context. Reasons mentioned why people practice FP were health of the mother, economic considerations, rapid population growth (lack of land), ability to care for the children and provide education for the children, and (especially for unmarried people) to prevent unwanted pregnancies which would interfere with education and lead to social stigma for the girl. In contrast, reasons why people are against FP relate to cultural ideas and practices about having many children, e.g. that children give prestige or that it is good to have large families as children might die. In addition, there is a perception that women who use PPM are more likely to have sex with other

men besides their husband. Religious beliefs play a role as well, as people often see children as a gift from God which should not be refused.

Gender roles is an important theme within FP. Men and women often have different responsibilities which are reflected in FP decision making as well, both for married and unmarried couples. Males are often regarded as the head of the household, as wiser and more rational, and therefore they take decisions. However, where couples do not have an open dialogue or do not agree about FP, women resort to secret use of PPM. Communication within marriage about FP is stimulated by many partner organisations as well as by some community leaders.

Stories about side-effects of PPM are many, are sometimes vague, and often play an important role in decision-making. Many women fear side effects of PPM such as on-going bleeding, backache, headache and infertility. Sometimes these side-effects are a result from a wrong or inconsistent use of methods. Nevertheless, both side-effects and myths about side-effects are a significant barrier to the use of FP methods and should therefore be addressed.

The use of (some) FP methods is condemned by some religious leaders, especially when it comes to youth. However, large differences could be seen and sometimes religious leaders encouraged FP (within marriage) and set an example themselves. While in the past most churches encouraged multiplication, perspectives are now shifting towards taking proper care of one's children. Additionally, while some churches condemn FP use, individual members may still use PPM. Another focus that we identified is on marriages and couples which then encourages discussion on FP. Nevertheless, when it comes to PPM for unmarried people, most churches limit themselves to teaching abstinence.

Potentials and challenges

Our third research question was: *What are challenges and potentials of the various FP programs concerning voluntary and informed decision making and access to contraceptives?*

1. Our data suggest that investing time and resources in specifically addressing community and religious leaders, both men and women, to gain their support for FP programs is very much worthwhile. They can influence public debate about FP and facilitate change.

2. Church leaders in several places felt it was attractive to be able to call upon a Christian NGO worker who could address the church members about issues of sexual and reproductive health. Staff of faith-based partner organisations can show leadership and influence a wide audience in this way.

3. In all three countries visited, effective dissemination of information and distribution of PPM was possible through existing networks of either the government or NGOs. Investing in the training of existing extension workers who discuss FP options, deliver methods and address community groups (including youth groups) will increase their impact. A link between the FP program and the Uchembere program for safe motherhood in Malawi proved productive and should be expanded.

4. There are many advantages to an open dialogue between partners about sexuality and FP. Although FP services should not be rigid or dogmatic about only counselling couples, our findings suggest that there is good reason to think creatively about policies that encourage men to participate.

5. The program in Jimma, Ethiopia, made computers available to youth groups so that they could access information about sexuality and discuss this. Our observations suggest that there is a lot of scope for the formation of youth groups where life skills and sexuality can be discussed. These can very well be run by churches but also by schools or through a health program.

6. Youth friendly FP services were pioneered in Ethiopia and were well-known and utilised among youth. This concept can be translated to other settings.

7. Dummy posters, to which actual samples of available PPM are attached, are a simple but effective tool to present FP information Encourage FP staff to make Dummy posters which display all PPMs that are available in a given clinic.

8. A huge challenge that emerges from the present research is that of encouraging open conversation about the discrepancy between the theory and practice of adolescent sexuality. This is clearly an area where dialogue between partner organisations in the Netherlands and in Africa, based on shared Christian principles, holds a lot of promise.

9. Although side-effects of PPM play an important role in the informed and voluntary decision making about FP in Africa, preciously little objective knowledge is available about these side effects to either the staff of the FP programmes or to the clients using FP. Our data demonstrate an urgent need for more information about side effects to be made available in forms that can be easily understood.

10. Our findings illustrate once more what every seasoned health manager in Africa knows, namely that to operate an effective program, the basic ingredients such as training, supervision, protocols, incentives and materials require continuous, energetic and loving attention. At a minimum, every programme that offers FP services should have staff that is adequately trained in counselling and is qualified to deliver contraceptives such as injectables and implants.

For the full research report, please contact Anke Plange (aplange@prismaweb.org), or see [link to website]