Family Planning choices within marriage and before

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

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Glossary & Abbreviations

AdS – *Armée du Salut*, the partner organisation of Leger des Heils (coPrisma) in Bukavu, South Kivu (DRC) with an FP program in an health clinic in Nyamuhinga (part of Bukavu).

ADED – *Appui au développement de l'enfant en détress*, the partner organisation of Red een Kind (coPrisma) in Uvira with an FP program in Minembwe, a city in South Kivu.

Aire de Santé – Region within a *zone de santé* with one health centre.

ARV – Anti Retroviral Drugs

ASHIDO - Community centre in Kirkos subcity in Addis Ababa. Partner of Dorcas Aid Ethiopia.

Bukavu – City in DR Congo (South Kivu), research took place with AdS in the area of Nyamuhinga.

CBD - Community-based Distributor (Malawi)

CPI – Client-Provider Interaction, where the provider is a staff-member of a health clinic or organisation providing FP services to the community.

DR Congo - Democratic Republic of Congo

EKHC- Ethiopian Kale Hiwot Church.

FARDC - The Armed Forces of the Democratic Republic of Congo (French: Forces Armées de la République Démocratique du Congo). State organisation responsible for defending the Democratic Republic of the Congo.

FGA - Family Guidance Association: another NGO active in promoting FP in Ethiopia.

FGD – Focus Group Discussion, a method used in the research with a group with people from a certain background, focused on a certain them, where participatory methods are used.

FP – Family Planning

HEW - Health Extension Workers - Nurse employed by the Ethiopian Ministry of Health, with tasks to go home to home to promote the 15 health & hygiene points of the government and to explain about **SRHR** issues at schools.

HIV – Human Immunodeficiency Virus, a slowly replicating retrovirus that causes the Acquired Immuno-Deficiency Syndrome (AIDS)

Implant – A hormonal contraceptive, placed in the upper arm of a woman. The (brand) names mentioned by people during our research are Norplant and Jadelle. However, also Implanon is a brand name we found at the health centres/hospitals, together with Jadelle, and it is said that Norplant is not used any longer. Officially, Norplant and Implanon prevent pregnancies up to 3 years, and Jadelle up to 5 years. If we use the word implant, we cannot guarantee which brand name is meant.

Injectable – A hormonal contraceptive, injected into a part of the body of a woman. The brand we saw mostly is Depo-Provera, and in Ethiopia Confidence. These injectables last up to 3 months, and contain 150 mg Medroxyprogesterone acetate.

IUD – Intra Uterine Device

JMA - Jimma Medan Acts: an HIV prevention and care program organised in Jimma by EKHC.

Kebele - the smallest administrative unit in Ethiopia, which covers the living place of around

500 families (around 4.000 inhabitants).

Kimbanguistes – A religion in DR Congo, founded by Simon Kimbangu in then Belgian Congo in the beginning of the 20th century. The religion is linked to Christianity.

Komanda – Town in DR Congo (Orientale) where the research with PPSSP took place.

Kuriftu – Town in Ethiopia

LAM - Lactational Amenorrhea Method, a natural birth control technique based on the fact that lactation (breastmilk production) causes amenorrhea (lack of menstruation).

Loop – Intra Uterine Device

Morning-After Pill – Emergency contraceptive in the form of a pill, possible to take up to 120 hours after conception.

NGO – Non-governmental organisation

Pill – A hormonal contraceptive, to be taken every day by a woman. Different brands with different contents are available.

PPM – Pregnancy Prevention Methods

PPSSP - *Programme de Promotion de Soins de Sante Primaires*, partner organisation of TEAR Netherlands (coPrisma) with FP program in Komanda (Oriental) DRC.

PWD – Person with a disability

Relais Communautaires – Volunteers, women or men, elected by the community to link the community to a health clinic. They receive training and organise awareness raising activities for different aspects of the health clinic (e.g. vaccination campaigns) and also for FP.

SRHR - Sexual and Reproductive Health and Rights

SSI – Semi-structured Interview – a method of data collection in which a list of questions is prepared, but where the researcher can adapt the interview to the circumstances.

STI – Sexual Transmittable Infection

SWOT- Strengths, Weaknesses, Opportunities and Threats

Uchembere progam - The Uchembere network implements reproductive health and safe motherhood in the 3 synods of the Church of Central Africa Presbyterian with support from ICCO.

Ushindi program – Program of PPSSP of which Family Planning is part, but which involves also youth groups, HIV/AIDS groups, violence based on gender etc.

Uvira – City in Congo (South Kivu) where the research with ADED was conducted.

WSWM - The World Starts With Me – Computer based sexuality education program, combined with discussion groups in which youth are educated about SRH.

Zone de Santé – Region with different *aires de santé* (around 15), with one hospital where people can be referred to.

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.

Table of Contents

1 Introduction

1.1 Background to the study

The ICCO Alliance is a partnership of Dutch development NGOs. coPrisma is a member of the ICCO Alliance and is itself an association of relatively smaller Dutch Christian member organisations. Basic Health & HIV/AIDS is one of the thematic programs in which coPrisma members participate, together with ICCO and Kerk-in-Actie. The Basic Health & HIV/AIDS program is implemented in twelve countries, eight of which are in Africa. The program pays special attention to sexual and reproductive health and rights (SRHR) including HIV with a focus on women, unmarried people (15–24 years), minorities and other disadvantaged groups. It intends to give special attention to the often large involvement and influence of religious leaders and churches in this area of thinking.

The ICCO Alliance, in particular coPrisma & ICCO, was interested in research to learn more about the ways in which Family Planning (FP) services are functioning among the African partner organisations. The present research was undertaken in order to gain learning and understanding on the difficulties encountered in the implementation of FP services. Such learning can then be used for capacity building of staff of FP services and making them aware of the needs of vulnerable groups.

1.2 Purpose & objectives of the study

The purpose of this research is to document perspectives and practices of partner organisations on how they support their beneficiaries in taking informed and voluntary decisions related to FP and provide access to contraceptives. Furthermore, this study will seek to identify potentials i.e. will seek to gather learnings from programs that are functioning well resulting in recommendations for further program development.

1.3 Theoretical framework[1]

Family Planning (FP) is an important theme as the most common causes of maternal mortality in developing countries are unwanted, mistimed and unintended pregnancies. Other reasons for promoting contraception include the prevention of sexually transmitted infections through barrier methods and limiting population growth which results in more resources and better education for the children that are born. Many organisations, however, struggle to successfully promote the appropriate use of FP methods. These struggles can be found at the level of the client (community member), the service provider and the overarching level of the social context. In this study we focus on the challenges of FP programs at these three levels. Additionally we pay specific attention to the relationship between FP and religion, and on FP and youth as they are often ignored in studies but have a high need in terms of FP. Our theoretical framework is partly based on the framework of Engender Health (Engender Health, 2003). The five points of Engender Health will all be discussed throughout the results sections rather than be assigned to one or more specific sub-sections.

1.3.1 FP at the level of community members

At the level of community members, struggles for people to make an informed and voluntary decision on FP relate to personal characteristics (gender, age, marital status, education, cultural and religious background) while the knowledge on FP, type and quality of information sources, and policies play a role as well. We specifically stress that, especially for African societies, individuals

[1] A full literature review with references is given in an annex.

often do not take decisions entirely on their own. People are embedded in a specific social context (church, family, community) and this will influence their informed and voluntary decision making.

1.3.2 FP at the level of service providers

From the side of service providers, there can also be all sorts of reasons why FP cannot be successfully implemented. From the literature we learn that struggles relate to physical and social accessibility of FP services, availability of contraceptive methods, and capacity (skills, knowledge, and attitude) of staff. Service providers and their clients are part of a wider social context and therefore all deal with norms, values and policies.

1.3.3 Youth and FP

Youth are hardly included in studies on FP. Most research focuses instead on decision-making of married couples and parenthood. There is however a high unmet need amongst young people as they lack information and cannot access FP services. As it is more likely for this target group to have unprotected and non-consensual sex, there is a specific need to include them in FP programs. Reasons for why youth are not included in FP programs may, amongst others come from taboos about pre-marital sex, from shyness and inability of parents and children to discuss sex, from the idea that talking about sex encourages sexual behaviour, and from governmental policies regarding sexual behaviour of youth.

1.3.4 Religion and FP

We focus specifically on issues that arise from religious beliefs as they may explain a significant part of acceptability issues and the prevailing sexual morality; and on issues that are specific to young, unmarried people. We expect that churches and community leaders may play a crucial role in providing information. Especially some religious schools of thought may be more open to teaching sexual health and the use of FP methods than others. Norms and values are often shaped within religious communities that may spread certain ideas about the autonomy of women, about individual agency, sexual morality, family size, and more specific about the use of contraceptives. Furthermore, clients need a safe and accepting environment in order to ask for advice and make use of contraceptives. Especially religion-based organisations need to be conscious of the potentially negative association of FP and religion in the minds of their clients which might endanger such a ‘safe and accepting environment’.

1.4 Research questions

The central research question for this study is: What are practices, perspectives and potentials of partner organisations on voluntary and informed decision making regarding FP and access to contraceptives? This question is operationalized as follows:

1. What are the practices of partner organisations on voluntary and informed decision making regarding FP and access to pregnancy prevention methods?
2. What are the perspectives on voluntary and informed decision making regarding FP and access to contraceptives? (using the 5 elements of Engender Health)
3. What are challenges and potentials of the various FP programs concerning voluntary and informed decision making and access to contraceptives?

2 Methodology

2.1 Phase 1.

2.1.1 Literature review

In a literature review, an understanding was created in the current thinking around Family Planning (FP) and its challenges. The literature review focuses on the following themes: unmarried people, accessibility, voluntary and informed decision making, religion and gender. Furthermore we acquired region (Sub-Saharan Africa) and country specific literature for DR Congo, Ethiopia and Malawi.

2.1.2 Selection of sites for field visits

A mapping exercise (June 2013) with 61 partner organisations of the ICCO-Alliance showed that the emphasis for most partners is on interventions for HIV/AIDS and on sexuality education for young people. Much less attention was given to family planning services. Data collection was conducted in three different local partner organisations in three different countries (DR Congo, Ethiopia, Malawi), which were selected by coPrisma because they had indicated during the mapping exercise that they have activities in the area of FP.

2.1.3 Workshop

During a three day workshop, the researchers prepared different parts of the methodology such as the focus groups, and were trained in using participatory methods. Attention was given to the importance of standardisation of the data collection and a list of important themes was developed. As part of the workshop two focus groups were conducted with African women living in Wageningen, where the methodologies were tested and information was acquired on FP in the African context, seen from the perspective of the participants. Afterwards we adjusted our methodologies with what we had learned during these focus groups.

2.2 Phase 2.

2.2.1 Field work & field workers

Three researchers visited three different countries and were assisted by locally recruited counterparts. The research counterparts helped to understand the local context, did translation and carried out some parts of the research independently. Ms Marije Cornielje, aged 25, is a development sociologist with working experience in Nepal and Bangladesh. She visited in Malawi and was assisted by Mrs Sella Ngoma, aged 38, married, dental assistant with three children, and previous experience in studies on health, HIV and Family Planning. Mrs Geertje Dingemanse (age), a graduate in International Development Studies, went to Ethiopia where she was a researcher and teacher before. She was assisted in Addis Ababa by Ms Liya Teklu (23), a pharmacist with broad experience in qualitative research on health-related themes. Outside the capital she was assisted by Ms Meskerem Hailu (27), health-expert and program officer of Dorcas Aid Ethiopia. Ms Wilma Smilde (29) graduated in Rural Development Sociology and had previous experience in South Sudan, Burkina Faso, Armenia and China. She went to DR Congo, where she was assisted by Ms Espérance Kwalava (30), with a background in community health, experience in research and working in prevention of HIV/AIDS among youth. Thus all field work was done by young, highly educated women who had a Protestant background and therefore were able to personally relate to the issues being studied. Each visit to a program had a duration of 4 days and was completed by a feedback

session in which staff were given an overview of the major findings and could comment or correct as necessary.

2.2.2 Participatory observation

With the help of a check-list, the place where the FP service was offered was observed. Points of interest were the quality of the building (running water, electricity, toilets, waiting room, and accessibility), the attitude of the staff present, the number of clients, the information about the services, promotion material and the availability of contraceptives. Photos were made of building, promotion material and contraceptives.

2.2.3 Informal interviews

During the participatory observation, informal interviews with clients were held. Mostly clients were waiting to be helped. As not all places of observation were offering solely FP services, also other clients who came to visit the other health services in the clinic were interviewed, and these clients were asked about their opinion on and use of FP services, in order to understand the attitude towards FP of visitors of the clinic.

Furthermore the researcher visited the community and talk with people of a different age or gender than already talked to during the informal interviews in the health centre. These interviews served different goals: to understand how other community groups viewed FP and the program or clinic that offered the services; to cross check if views of certain groups of people, understood in other parts of the research (such as focus group discussions), would be shared by similar groups in the community.

2.2.4 Observation of client-provider interaction (CPI)

A researcher would take part in the CPI to be able to observe the attitude of client and service provider to understand the counselling from practice. Beforehand, we realised there would be certain barriers such as the confidentiality. However, in practice we realised that there were other reasons that made it difficult to be present at a CPI, as sometimes it was hard to find out when a CPI would take place, and in other places there was no time to organise to be present at a CPI due to the travelling and other research components taking place at the same time. However, in Ethiopia it was possible to attend four CPIs and it gave us valuable insight in the way women (clients) and nurses (providers) interacted on FP.

2.2.5 Vignettes and role plays

During the following methods, short stories (for example on a girl who asks for FP advise) called vignettes were shared or role plays were done. These methods helped to elicit opinions and views and to understand how religion and culture play a role in shaping ideas on FP. It also gave an impression of how staff would advise certain people coming for FP services. An overview of the vignettes and role plays is given in an annex.

2.2.6 Semi-structured interview with staff members and team-leader

Semi-structured interviews were held with staff members of the partner-organisation and/or with staff of the clinic where the FP service were offered. During these interviews an understanding of the FP program was made from the point of view of the provider, and the focus was on the different groups coming for FP.

During the interview with the team-leader, similar questions were asked, with a stronger focus on the vision of the team-leader. The interviews also helped to understand if there was a big difference in knowledge, vision or thinking between the team-leader and the staff.

2.2.7 Semi-structured interview with community leaders

Semi-structured interviews were held with community leaders: church leaders (pastors, in all three countries), women church leaders (DR Congo, Malawi) and chiefs (Malawi, Ethiopia). During these interviews, the focus was on the views of the leader regarding FP, for married and for unmarried persons, and on his or her role in the community and in relation to FP. In DR Congo, community leaders were interviewed in small groups.

2.2.8 Focus Group Discussions with (un)married women and men

Separate groups of unmarried women, unmarried men and married women were formed (3-12 people per group) and a focus group discussion was held. The methods used in these focus groups were: vignettes, discussion, time-line, gender-matrix, brainstorm, ranking, mapping, ideal family, probing and specific questions. With these methods, and understanding was formed of how people viewed an ideal family, an ideal husband/wife, FP, contraceptives and the clinic or partner-organisation. Often groups did not have a homogeneous opinion, and discussion gave a lot of insights into the different viewpoints within the groups.

2.2.9 Focus Group Discussion with staff

The staff of a partner-organisation was gathered for a focus group discussion. Methods used were: vignettes, role play and SWOT (Analysis of Strengths, Weaknesses, Opportunities, Threats). The first methods gave an insight in how staff members reacted to clients asking for FP, and helped to understand their thinking on FP with regard to religion, culture and personal opinions. The second method helped to assess the way in which the staff themselves understands the FP program and the context in which it works. During the SWOT, the researcher would only ask questions to clarify, and in the end the researcher would compare the information with the data found during the other parts of the research.

Table 2- Number of participants by method and country

Method	DR Congo	Ethiopia	Malawi
Informal interviews	25	25	5
SSI Staff	6	11	4
SSI Team leaders	4	3	3
SSI Men leaders	11 (3 grps)	6	5
SSI Women leaders	15 (2 grps)	2	1
FGD unmarried men	22 (2 FGD)	25 (4 FGD)	19 (2 FGD)
FGD unmarried women	21 (3 FGD)	24 (4 FGD)	16 (2 FGD)
FGD married women	30 (4 FGD)	28 (4 FGD)	16 (2 FGD)
FGD staff	18 (2 FGD)	19 (3 FGD)	11 (1 FGD)
Total participants	**152 (incl. 24 staff)**	**143 (incl. 23 staff)**	**70 (incl. 18 staff)**

2.2.10 Ethical consent

Before an interview or Focus Group Discussion, the researchers took care to explain the confidentiality of the research and the information shared, and explained that it was allowed to stop the interview or not respond to questions at any time.

2.2.11 Differences per country / themes

Due to the differences between the researchers, the partner organisations and the differences between the countries, data gathering in each country differed. The main differences are: role play only used in Ethiopia, CPI observation only in Ethiopia, no chiefs interviewed in DR Congo, and minor differences in methods used during FGDs (such as the use of different vignettes).

Nevertheless, during the research all researchers took care of covering the following themes: Information on contraceptives, FP and unmarried people, FP and religion, sexual moral, the image of the organisation and the accessibility of the services. Another theme that proved to be important from the start of the research was the prevalence of side-effects of contraceptives. The covering of the different themes was decided to be more important than the use of specific methodologies; all researchers covered the different themes.

2.3 Phase 3.

In a three day workshop, the researchers came together and shared the data gathered during the visits of the partner-organisations. Data were gathered around themes and groups, and similarities and differences between countries and places were highlighted. Challenges and good practices were discerned and a foundation of the report was laid, elaborated in the days after the workshops.

3 Background information of programs visited

3.1 DR Congo

3.1.1 General information

The research took place in the province of South Kivu and in the province Orientale. These provinces are strongly affected by the on-going conflict between rebels and the FARDC (government army), causing tension and a slower pace of development in these regions. Furthermore, it has caused many people to flee from the rural areas to the cities. In some regions it is dangerous to travel and this can cause health centres to be (temporarily) inaccessible.

Health care in DR Congo is organised in *zones de santé* which each have one hospital. A *zone de santé* is composed of around 15 *aires de santé* which each have a health centre. FP services are officially included in the basic package of the health centres, but are not always available. The partner organisations help to strengthen these services e.g. with financial means, providing contraceptives, training and coaching. The organisations visited in DR Congo are all partnering with health centres of the government.

3.1.2 Armée du Salut (AdS)

AdS funds and coordinates an FP program in the health centre of Nyamuhinga, in the city of Bukavu. The population of Nyamuhinga is 17,056 and in 2013 there were 626 women who used an FP method. The clinic gives information about FP to pregnant women and young mothers, and gives counselling to women interested in FP. They give information on natural FP methods and other birth control methods which are available in the clinic.

AdS has many different programs in DR Congo, and works together with various health centres, churches and other programs.

The registered nurse and the *relais communautaires* invited people for the FGDs, for the interviews the researcher selected the informants.

3.1.3 Appui au développement de l'enfant en détresse (ADED)

ADED operates its FP program in Minembwe, a town in South Kivu. The city is difficult to reach, the area is mountainous and the literacy rate is low. FP is not accepted by the majority of people, and pastors are said to be hostile to the FP program. Yet, there is a slight change in attitude, created by some awareness raising training of pastors, *relais communautaires,* and mothers. However, FP methods are often practiced in secret. The official proportion of women who use an FP method is 4.7%. The data collection was carried out during one day in Uvira (4-6 hours from Bukavu, and 10 hours from Minembwe) where ADED has its offices. Group interviews with church leaders were organised by a local church at the request of ADED; an FGD with women from Minembwe was organised by ADED staff; the interviewer selected staff members for informal interviews.

3.1.4 Program de Promotion des Soins de Santé Primaires (PPSSP)

PPSSP has an FP program (called Ushindi) in Komanda, in the south of the province Orientale, 125 km. north of Beni. In Komanda, they work with the hospital and with 7 of the 15 *aires de santé* of Komanda. The program only just started in 2012. Komanda is a safe place in the midst of an area where rebels have a strong influence, and many refugees have fled to Komanda in the past 10 years, creating an unstable population.

PPSSP has some other programs in Komanda, such as an HIV/AIDS program and a program focused on the development of children. The programs are working together in reaching the population.

Staff-members working in Komanda organised the FGDs, people for the interviews were selected by the researcher.

3.2 Ethiopia

3.2.1 General Information

The government health system has the following structure: hospitals; health centres; health posts; health extension workers (HEW). The HEWs are nurses and perform home visits to explain 15 health priorities from the government, of which FP is one.

The contraceptive acceptance rate is 56% according to the Ethiopian Ministry of Health (2013) but 29% according to another source (cf. Table 3-1). Most women use injectables and second in popularity is the pill. Recently, the government decided to promote the long term contraceptives (loop and implant). The partner organisations in Ethiopia selected for fieldwork are very diverse in their activities and size. Also the cultures in which they operate are very different: from urban to rural and from a dominantly Christian area to a dominantly Muslim area.

3.2.2 ASHIDO

ASHIDO is an Urban Development project. There is an elderly day centre, a library for youth, a child and orphanage sponsorship program. The program supports the whole Kirkos community, a suburb of Addis Ababa. ASHIDO has a small health post which is supported by Dorcas International (5 staff members, of which one nurse) since 2001. The health post offers small medical treatments, syrups and painkillers and FP services. For the other activities, it refers to the government health centre in Kirkos. Per day around 3-4 married women come for injectables and pills; additionally some unmarried men quickly come and go with condoms from the *condom corner*. Unmarried women do not come here (1 case in 2 years) since everyone knows each other, and no unmarried girl wants it to be known she is sexually active.

Earlier the health post had a main role in making modern FP methods available, but nowadays the government Health Centre took over this role, since it has more resources and offers more FP options. The focus of this research is, however, on the FP program of ASHIDO itself. Two board members of ASHIDO were interviewed as community leaders. The participants of the FGDs were partly selected by the staff of the health post and partly by ourselves (youth studying in the library).

3.2.3 EKHC Kuriftu

EKHC is a large Protestant church with many activities in their Development Program. In the rural areas around Derbrezeit (45 km SE of Addis) they have many programs, some supported by Tear NL, of which one is the HIV/AIDS prevention program (Dereje, 2014).

The intervention area is a rural area without electricity and very sparsely populated. Most people are Orthodox Christians, some are protestant. The main aim is to improve utilisation and quality of the government health centre in Biyo and the 6 health posts in the kebeles, in order to improve (maternal) health and to reduce STIs. Staff of the Biyo health centre is well trained, also specifically on FP and youth counselling. On average 12 women come for FP services per day, of which 3 are not married. For our research, a kebele chief, the women group leader and an Orthodox Priest were selected to be interviewed as community leaders. The FGD participants were selected by school and kebele leaders. The local language is Oromifa.

3.2.4 Jimma Medan Acts

Jimma is a green city, 300 km SW of Addis, with a university. Around 90% of the inhabitants are Muslims. Jimma Medan Acts is a program of EKHC specifically focussed on HIV prevention and care for people infected with HIV, supported by Tear NL. There are three staff members (organizing the program) and many supporting staff and volunteers. The role of FP in this context is very small. Since December 2013, the program focuses on providing information to youth via implementing the World Starts With Me (WSWM) program via schools and youth clubs. Our data collection was focussed on the HEWs and the youth clubs, since WSWM is the main activity of the FP program presently offered by Jimma Medan Acts. For our study the following three community leaders were selected: the head of the health program of the kebele (f, Muslim), a community savings project leader (m, Orthodox) and the kebele leader (m, Muslim). The unmarried FGD participants were invited by the youth club leaders, while the married women were invited by the HEWs.

3.3 Malawi

3.3.1 General information

The research took place at two hospitals where the program was functioning: one hospital in the northern region (Embangweni), and one in the central region (Nkhoma). The Uchembere network is implementing reproductive health and safe motherhood in the 3 synods of the Church of Central Africa Presbyterian with support from ICCO. Uchembere aims to improve the quality and accessibility of reproductive health services, promote partnerships in the implementation of reproductive health programs and improve the referral of reproductive health emergencies.

The government of Malawi supports the practice of FP by providing FP methods to all the hospitals in the country. About half of the married women use contraceptives of which injectable, condom, pill, and sterilisation are mostly used (Studies in Family Planning, 2012).

3.3.2 Uchembere - Embangweni

For Embangweni, the Uchembere program is combined with the FP program of the hospital. As a result, community outreaches focus on both safe motherhood and FP. The hospital has around 130 beds (2013) and serves a population of about 100,000 people, with referral cases often coming from much further away, including Zambia. Health care delivery occurs in 16 village centres as well.

The FP program of Embangweni hospital includes four trained nurses and a number of other (assisting) staff. Besides counselling on FP, they also distribute ARVs, provide HIV tests, give antenatal and postnatal care and conduct screening for cervical cancer. The FP program together with Uchembere has a catchment area population of 33,323 people.

In addition, Embangweni is located in a very rural and agricultural area. In the village itself there are two churches: the Presbyterian and the Roman Catholic Church. Besides the religious leaders, the chief is an influential person in town.

3.3.3 Uchembere - Nkhoma

Nkhoma hospital has been in existence for over 98 years and is a result of missionary work. Presently the hospital is a 240-bed hospital with medical, surgical, paediatric, maternity, ophthalmic and TB wards. FP services are an integral part of the reproductive health services, and work independent from Uchembere. In 2012 over 9000 clients received contraceptives. Normally five nurses work in the FP clinic.

The Uchembere program here aims to attain comprehensive sexual and reproductive health services that are accessible, acceptable, effective and safe to individuals, couples and communities in

Nkhoma and surrounding health centre catchment areas. The Uchembere network has one staff leader and a number of Community-based Distributors (CBDs), key informants and facilitators. Uchembere reaches out to communities in 6 different districts. While the focus is on safe motherhood, the CBDs and key informants also provide pills, condoms and (FP) counselling to community members.

Nkhoma hospital is located an hours' drive from Lilongwe. The Roman Catholic and Presbyterian churches are the largest churches here and have strong (mostly aversive) ideas about utilisation of FP by unmarried people. Surrounding areas are similar to Embangweni - very rural and difficult transport. In the villages, the chiefs play an important role in terms of decision-making, norms and values.

Table 3-1. Country statistics.

		DR Congo	Ethiopia	Malawi
Population[1]		77.433.744	96.633.458	17.377.468
Age structure[1]	0-14y	43%	44%	47%
	15-24y	21%	20%	20%
	25-54y	29%	29%	27%
	54-64y	3%	3%	3%
	<65 y	3%	3%	3%
Population growth rate[1]		2,5%	3%	2,5%
Fertility	Births/1,000 population[1]	35,62	37,66	41,8
	Mother's mean age at first birth	20,2[3]	19,6[7]	18,9[4]
	Maternal deaths /100,000 live births[4]	540	350	460
	Infant deaths /1,000 live births[1]	73,15	55,77	48,01
	# children born/woman[1]	4,8	5,23	5,66
	Contraceptive prevalence rate among married women in age of reproduction	18%[4]	29%[3]	46%[3]
Health care	Physicians/1,000 population	0,11[9]	0,03[5]	0,02[6]
	HIV Prevalence[2]	1%	1%	11%
	Health Expenditures (% of GDP)[3]	9%	5%	8%
Development	Literacy	67%[4]	39%[7]	75%[4]
Religion	Roman Catholic	50%	1%	-
	Protestant	20%	19%	83%
	Muslim	10%	34%	13%
	Traditional	-	3%	4%
	Ethiopian Orthodox	-	44%	-
	Kimbanguist	10%	-	-
	Other	10%	1%	-
Poverty	% of population under poverty line	71%[8]	39%[2]	53%[9]
	Labour force in agriculture	NA	85%[5]	90%[10]

Source: CIA factbook. Year of the (estimated) data: 1: 2014; 2: 2012; 3:2011; 4:2010, 5:2009, 6:2008, 7:2007; 8:2006; 9:2004, 10:2003. (HIV-data confirmed by UNAIDS)

4 Results (1): Practices

In this chapter, data on the availability of FP services – information, counselling and actual pregnancy prevention methods will be presented. The quality of these services will, to the extent possible, be discussed in section 4.2 while accessibility of FP services will be considered in section 4.3. A final section will briefly address *changes* in the services over time.

4.1 Availability of services

4.1.1 Information

4.1.1.1 FP promotion by partner organisations

In Ethiopia staff is trained by the partner organisation and uses manuals from the government in order to give information about FP. They teach clients mainly about different types of contraceptives. Staff also provides information on side-effects but the information is not always complete or based on facts. In Malawi clients are mainly taught on safe motherhood topics, but also on FP, HIV and cervical cancer. Uchembere in Nkhoma does not work much together with the FP clinic and so they focus mainly on safe motherhood while missing the opportunity to speak about FP. In one clinic in DR Congo, staff also showed a manual they had gotten during a training, which they used as background information if they had questions on FP.

Poster with FP methods from Malawi: Everybody has the right to choose what method to use

In what follows, we present many other sources by which people learn about FP and these may differ between married and unmarried people. Sometimes this information and these sources are much more important for people in terms of their decision-making on FP than information presented by the FP program.

Promotion campaign for contraceptives in Ethiopia, highly supported by the government

4.1.1.2 Health promotion through the media

Media are another source for health promotion. In urban settings in Ethiopia the policy of the government is promoted through radio and TV. In this way people of all ages are included. Radio is used in Malawi and DR Congo as well. For a small organisation, however, radio programs are expensive to run so they are not always an affordable channel to reach people. FP related posters on the streets and in the clinics in Ethiopia are another source, whereas in DR Congo and Malawi, posters or pictures are mainly used as a tool for nurses during counselling and in FP awareness campaigns to explain details of FP during their talks.

4.1.1.3 Married people

Promotion of FP for married people happens through different channels such as the clinics (or health workers), *relais communautaires* (DR Congo), HEW (Ethiopia), CBDs (Malawi), churches, chiefs (Malawi), media, other NGOs (e.g. Family Guidance Association and Marie Stopes in Ethiopia). Furthermore, informal channels such as friends are important sources of information. The different types of community health workers mentioned above are especially important for married women who are visited at home and advised about FP. Furthermore, chiefs in Malawi can be important sources of information as they promote FP in their meetings and visit families that tend to grow large: Chief Malawi – *"When people are not educated it is hard for them to see why FP is important. (..) I speak about it whenever there is a meeting. Also, at funerals I speak about FP as there is a very diverse group together and all of them need to know."*

4.1.1.4 Unmarried people

An important information source for young people in Ethiopia are the HEWs who are asked to speak in the youth-group of the church and also at schools. HEWs also distribute sanitary towels and condoms at schools for the children older than 12 years. For the somewhat older children peers (trained by the partner organisation) are used instead of HEWs and they give information on FP and sexuality but not about good marriage. In terms of youth groups, in Ethiopia such groups provide In much information and youth is well-aware of the negative aspects of premarital sex. Youth groups are sources of information for youth in DR Congo as well. In Malawi youth groups were lacking and unmarried people expressed their specific interest for such groups.

Box 1 - WSWM implementation in Jimma

Medan Acts decided to provide the WSWM program for the youth and students in Jimma. They chose two channels: the youth club (50 members, drama, HIV-related, government supported) and the high school. In December 2013 four youth leaders and four high school biology teachers attended a 5-6 day training in the WSWM program. They went through the lessons and practiced facilitating the group discussions. JMA provided computers to the youth club and made available their own training centre (incl. computers) for the high school students. Currently 60 people completed the 16-lesson training: 25 in the youth centre and 35 in the school. 112 people are underway and the 2014 target is for 500 young people to complete the training. The teachers invite their students and the youth club asks trainees to bring others. The image of the WSWM is very positive among adults and youth. Some topics, like homosexuality are negatively reviewed, but other topics and the entertaining elements are very much appreciated. Already the fact that an NGO trusts them and provides computers for free greatly boosts the image of JMA. Still, some youths cannot participate. Especially poor people, who have to generate their own income, tend to not respond to the teachers' invitation and are also not a member of the youth club. If the Ethiopian government would make WSWM a part of the educational curriculum, the coverage of the program could be increased.

In schools in Ethiopia the materials of WSWM are used and youth are positive about this as it is more fun and more interesting than biology class. In DR Congo, youth (especially males) mentioned the biology class ('Education à la Vie' or 'Hygiène familial') as their sole official source of information on sexual and reproductive health. Through WSWM youth learn from trained peer educators. Working

with peers was mentioned to be very effective in all three countries. In one place in DR Congo, a person from each class was invited for training and acted as a peer educator. Health workers in DR Congo are however not allowed to bring condoms to the schools (issue of age cf. 4.3.2.1) but the workers tell the youth where they can get the condoms anyway. Peer educators can also play an especially important role in reaching youth that are not enrolled in school.

Two places where the WSWM is implemented in Jimma, Ethiopia: a youth club (l) and a training centre at school (r)

Parents in all three countries promote abstinence, although there are (rare) exceptions, such as a Congolese father who makes condoms available to his children, or an Ethiopian father who has his children tested for HIV every six months. In Malawi uncles, aunts and grandmothers are more likely sources of information for youths than parents since youths are often too shy or embarrassed to discuss sexuality with parents. Parents sometimes educate their children indirectly through the use of stories about bad examples of youth that got pregnant. In practice, friends are often a more important source of information than family although the information might not always be correct.

4.1.2 Counselling

Counselling is provided in most places where FP services are offered. Often counselling is seen as giving information on FP options in an individual talk between the nurse (provider) and the woman (client). However, the way of counselling varies greatly between clinics. In clinics in Ethiopia and outreach clinics in Malawi, there is often no privacy for counselling: the room does not have walls, or they are partly open, and there is no coverage on the windows. By contrast, in the *hospitals* in Malawi and in both health centres visited in DR Congo privacy was ensured. The quality of counselling is discussed in section 4.2.2

A typical counselling room in a health clinic in Ethiopia. Although there is a curtain, it is still possible to look inside, so privacy is not ensured.

4.1.3 Pregnancy Prevention Methods (PPM)

The availability of the various pregnancy prevention methods has been summarised in Table 4-1 by program visited. Since programs collaborated with different types of health facilities, the availability

varied accordingly. The programs in Malawi worked out of a hospital and two of the programs in DR Congo supported a *zone de santé* which included a hospital and health centres. The programs in Komanda (PPSSP) offered the widest range of 10 choices, respectively, from natural methods to sterilisation, followed by Embangweni with 9 choices, which did not include natural methods but where Morning After pills could be obtained if needed.

At the other end of the spectrum, programs that offered only three options had condoms, pills and injectables. These were programs that only operated a health post (ASHIDO) or that worked through the Health Extension Workers (Jimma Medan Act). In Ethiopia an injectable can only be given by a qualified nurse, which limits its availability to the hours when this person is present. No medical prescription is needed in order to use pills, and they are available in health centres, provided by CBDs in Malawi and HEWs in Ethiopia, and obtainable in pharmacies and mini-shops. They are, however, not very popular. In all three countries pills are used as second choice by women who experienced too many side effects from other methods or do not have access to injectables or an implant. Mini-pills (a lighter variant) were available in two places (in DR Congo and Malawi). In DR Congo, a nurse indicated that these were given to women who approached menopause.

We found different types of implants: Norplant, Implanon (effective for 3 years) and Jadelle (5 years). Norplant was mentioned by a large number of participants in the research, but we are not sure if that actual brand name is still available, as we only encountered packages with the brand name Implanon. An implant should be placed by a well-trained nurse which limits its availability. In 4 of the 6 clinics we visited it was possible to get an implant and to get it removed. In DR Congo, women could also get an implant inserted by unqualified people of the pharmacy, but this is illegal, and may cause negative side-effects. In Malawi, implants were placed even in the mobile FP clinics. In one place in DR Congo, the method is so popular that the demand is higher than the packaged supply[2], resulting in waiting lists for women.

The table shows that natural methods were taken seriously only in DR Congo. It is our observation that natural FP methods are considered only effective for educated women who are able to discuss sexuality issues openly with their husbands, and who can understand how to interpret their cycle. Moreover a highly disciplined attitude is necessary to abstain or use a condom in fertile periods.

The IUD had been available in Embangweni but was not popular, possibly because of a rejection of this method by religious leaders (cf. 5.4.6.1). The available supply of IUDs had passed the expiry date and no new supply was ordered. The IUDs that had been available in EKHC in Ethiopia could not be placed because the instruments required for this were missing and so met a fate similar to the ones in Embangweni.

In Ethiopia and Malawi the availability of condoms was more than sufficient. Besides supplies from clinics and other health facilities, the program in Malawi made use of volunteers, community-based distributors, while in Kuriftu we met a youth leader whose job it was to distribute 1000 condoms a month for another NGO (condom ambassador). For unmarried people in DR Congo, condoms are only distributed through programs focused on HIV.

2 Packaged supply means that a certain amount of all different types of PPM is given, not reflecting the demand in the specific location.

Table 4-1. Availability of PPM in programs visited by place

Country	Ethiopia			DR Congo			Malawi	
Centre	Ashido	EKHC	JMA	AdS	ADED	PPSSP	Embangweni	Nkhoma
Type of centre[1]	HP	HC	HEW	HC	H+HC	H+HC	H+HP	H+HP
Natural methods								
Calendar method	no	no	no	no	-	yes	no	-
Cycle beads	no	no	no	no	-	yes	no	-
LAM (information on)	no	no	no	yes	yes	-	no	-
Hormonal methods								
Emergency Contraception	no	yes	no	no	no	no	yes	-
Injectable (Depo-Provera)	yes	yes	yes	yes	yes	yes	yes	yes
IUD/loop	no	no	no	no	no	no	no	-
Implant (Norplant/Jadelle)	no	yes	no	no	no	yes	yes	yes
Pill	yes	yes	yes	yes	yes	yes	yes	yes
Mini pill	no	no	no	no	-	yes	yes	-
Barrier methods								
Male condom	yes	yes	yes	yes	yes	yes	yes	yes
Female condom	no	no	no	no	-	yes	yes	-
Diaphragm	no	no	no	no	no	no	no	-
Sterilization								
Vasectomy	no	no	no	no	yes	yes	yes	yes
Tubal Ligation	no	no	no	no	yes	yes	yes	yes

[1]H=hospital, HC=health centre, HP=health post, HEW=health extension worker, - = No data.

Female condoms are less popular and also more difficult to use. Many people indicated that they did not know how to use the condom. In Ethiopia we did not see them supplied. Both in Malawi and DR Congo there were clinics where female condoms were supplied and used.

Tubal ligation and vasectomy are only available in hospitals. In Malawi the proportion of married women sterilised doubled from 5% to 10% between 2000 and 2010 (Studies in Family Planning,

2012). In Ethiopia and DR Congo voluntary sterilisation is not an accepted practice. Here sterilisation is only done for medical reasons e.g. on-going vaginal bleeding, ectopic pregnancy. Vasectomy is very rare, and most men are very much against it.

4.2 Quality of Services

4.2.1 Quality of staff / Training

Quality of staff has two different aspects namely knowledge and personal/social qualities. Training and coaching improves the quality of the staff in both, which adds to the quality of an FP program.

We found that in most clinics at least some people are trained in knowledge on FP and personal qualities in their work. These trainings are facilitated by the government, by the partner organisations or by other NGOs. There are, however, clinics where no staff-member is trained, or where the team leader is not trained in FP (Nkhoma, Malawi). A reason for lack of training could be that some clinics are located in remote hard to reach areas. Most staff have knowledge on the use and effects of the methods, but few know exactly how the methods prevent a pregnancy. To be allowed to put into place an implant staff needs to be trained; this is why not all clinics visited can offer implants (cf. Table 4-1).

Follow-up training for FP staff, where questions can be asked and problems encountered discussed, is occasionally given in DR Congo and Ethiopia but not in Malawi. In most clinics visited, staff feel the need for more training: "*A weakness is that there are no refresher courses for staff here" (FGD staff Embangweni)*.

In some programs, one person per clinic is given training on FP, and is expected to train other staff-members. However, in DR Congo, people mentioned that the frequent change in personnel causes loss of knowledgeable staff. One nurse in a clinic where no staff member is trained due to staff mutations said *"I feel very unsure about my knowledge on Family Planning".* In Ethiopia we found that different staff-members may give different advices and different reactions in the same situation. In Dr Congo and Malawi, there is often no manual of the FP information or a guideline for a conversation.

Other people who work with the clinic such as the *relais communautaires,* the CBD in Malawi and HEWs in Ethiopia are given training in FP as well. A CBD (woman) said that she is happy to be trained, because now she can help others with her knowledge. Other people are trained as well, for example in Malawi where a staff leader said: *"The program tries to identify key leaders (males) that are trained to support their own wives, and/or make use of contraceptive methods themselves, so they can be an example to other men"*. Leaders are also trained in some places in DR Congo and Ethiopia.

Another aspect of the quality of the staff is their attitude towards people. Many people who visited the different clinics said that staff is very friendly, welcoming and helpful and this is also mentioned by the community adding to the positive image of the clinic in all three countries.

4.2.2 Quality of Counselling

In counselling, the quality of the staff is important. We found that in many places counselling has an important role in the acceptance of a method. In Malawi, Ethiopia and in some places in DR Congo, counselling is a *prerequisite* before a method is given. A staff member in Malawi said *"I wouldn't just*

give the girl contraceptives, but would first of all encourage her to let her boyfriend accompany her to a counselling session. It is important that both get counselling."

In some places women can only come with their husband e.g. in Komanda (DR Congo) and in Malawi staff stressed the importance of the men joining their wives (or boyfriends joining their girlfriends) in the counselling, as FP should be a couples decision. In one clinic in Malawi, women who come with their husband are given priority and do not have to wait in line.

Some staff-members in Ethiopia and DR Congo mentioned the time pressure on counselling, which does not add to its quality, and clients spoke negatively about staff who did not seem to have time for them. In Ethiopia staff is specifically trained for counselling and learned two techniques to make information provision personally relevant: 1. To ask questions, 2. To say: if.. then.. Especially the second one is used, since women may be shy and do not or wrongly answer questions.

In some places in Ethiopia, a lot of time is spent on counselling, even if a woman already knows what she needs. However, in another place in Ethiopia, staff have very outspoken ideas of which method a woman should use and try to persuade her to adopt it. This behaviour appears to be linked to a government policy to promote implants.

A highly valued principle in providing FP services is to be enable women to make their own well-informed and voluntary choices (Engender Health, 2003). Clinic staff agrees on the importance of this, but in practice it is very rare that clients are fully informed and take their decisions completely voluntarily.

Choices are not always well-informed because:

- There are many information sources that misinform people about the use or effects of a PPM. It is hard for staff to disagree with the information given by the clients' family members and friends, especially if the client does not fully trust the modern health system. This is a threat that comes from outside the clinic.
- Within the clinic, sometimes staff do not mention all available methods; they may skip the methods people do not ask for (to save time) or the methods they do not prefer for religious reasons (cf. 5.4.6.1).
- Methods that are promoted by the government may be framed only positively by the staff.

Choices are not always voluntary because:

- Women live embedded in a society where many choices are made for them by others, e.g. their husbands, their mothers, religious leaders. Therefore outside the clinic, many others influence their choice which therefore might not be fully voluntary.
- For youth, the societal norm is abstinence and staff may limit the provision of contraceptives on these grounds.
- Emphasis on participation of the husband in counselling may stimulate dialogue about FP in marriage, but might also result in a choice favoured by the husband but not by his wife.
- Staff members may prefer specific methods, e.g. driven by government policy. This is illustrated in Box 2.
- The number of available PPM may be limited so that the preferred option cannot be obtained.

4.2.3 Quality of other services

The range of options from which a couple can choose when wanting to use a method differs. In a hospital, the range of methods is the widest, while in the more peripheral areas, the range of choices is limited to very few. In Malawi and Ethiopia, a CBD or HEW makes the condoms and pills available, yet in DR Congo, often the *relais communautaires* do not reach the most remote areas, and offer only condoms.

Dummy poster of contraceptives available in a health post close to Derbre Zeit Ethiopia

There are differences in how staff in different countries care for clients after they have adopted a method. In Ethiopia, women are invited to come back after one month to check if the method works fine. One nurse mentioned the availability of a medicine to counter side effects (such as prolonged and heavier periods). This kind of follow-up was rarely mentioned in Malawi and DR Congo.

Posters were usually available in counselling rooms in the clinics. A poster found in Kuriftu (Ethiopia) listed 11 methods, of which 2 are natural ones and 4 are offered in the clinic. There is information on how the methods should be used, whether it is advisable to use them and what the risk is of unwanted pregnancy. This poster was also translated in Oromifa, the local language. An illiterate lady told that she remembered the poster, since there were nice pictures on it. In Kuriftu there was also a 'dummy-poster': of each available type of contraceptive a sample was put on the wall. The posters are only put inside the building rather than outside where the waiting area is located. In Embangweni (Malawi), all posters are written in Tumbeka or Chichewa, except for two that were in English. The majority of the posters are developed by the Ministry of Health and Housing while others are from UNICEF and WHO. Most posters are about other health issues, whereas few are directly about contraceptives and FP. The posters are found in the waiting room of the FP clinic and in the offices of the nurses where they are used to better explain the details of FP. In DR Congo, posters are used in only one place during awareness raising sessions. Many people remember the example illustrated on the poster.

This poster is available in Malawi and Ethiopia, sometimes translated in the local language. Not all methods mentioned are available in the clinics.

A woman enters the consultation room for the first time and says 'please give me depo'. Her decision is already made, based on information from friends and relatives. Perhaps her choice is voluntary, but not well-informed. If she fulfils the medical criteria (no high blood pressure etc.) she will often get what she asked for.

When asked 'why do you choose for depo?', most clients answer that it also works for their neighbours. If the health worker mentions other options, the client may consider them not effective (natural methods, pill), weird and sinful (condom in marriage, sterilisation) or too modern and harmful (implant, loop). Now the task to let the decision be both voluntary and well-informed becomes very hard for the health worker, who has to compete with all other information sources that are valued by the client. S/he has to take into account that, for the client, non-existing side effects are as real as existing side-effects. All upcoming health problems can be interpreted as side-effects of the contraceptive. Just explaining the options neutrally and objectively may be less-convincing than a crying neighbour or a preaching pastor. Therefore nurses in Ethiopia raise their voice and explicitly condemn the (scientifically false) reviews of other people. During the conversation the clients' speaking declines and the nurses' argumentation increases. In the end the client is confused and accepts the implant. In observing the CPI, it definitely did not look as if the client was making her own voluntary choice. However, the nurse did not feel bad, since she 'saved' a woman from the old-fashioned misconceptions and misunderstandings. Raising one's voice and using one's superiority is considered OK if one wants to convince a client of the scientifically correct information.

Box 2 - Trade-off between voluntary choice and well-informed choice

4.3 Accessibility of services

4.3.1 Barriers

Financial: Women sometimes found out that the prices for methods could be three times higher than was suggested before. A lot was said about barriers in terms of money and it would be good if the correct prices would be mentioned so clients know better what to expect. For Ethiopia money was not so much a barrier: services were offered for free, except for a one-off administration fee of about 20 euro cents. Methods in Malawi are offered for free but the materials used for inserting Norplant for example are to be paid by the clients. For some women this was mentioned as a problem: *"The Norplant costs around 1000Kw (2 euros), which is difficult for them to afford. It is not really a lot of money but they have to prioritize."* (community member Malawi)

Mobile clinics in Malawi: buildings incidentally used for medical care and social meeting/trade.

Lack of privacy: In DR Congo privacy was ensured, whereas in Malawi there was hardly any privacy in the mobile clinics (although it was not mentioned as a problem). Muslim women in Ethiopia mentioned that they did not want to get a loop/IUD because then they would have to lift up their skirts in the presence of the nurses.

Service requirements: In some clinics people were obliged to receive counselling before they were given methods (Malawi and Ethiopia), and men mentioned that they were obliged to be tested for HIV when they accompany their wives (Malawi).

Transport: This is a huge problem, especially in DR Congo and Malawi, in terms of access to either the hospital or the clinics.

Education: In all countries, a lack of education makes it more difficult for people to understand information about FP. This makes it hard for people to understand what methods of FP to use and how and when to use them.

4.3.2 Excluded and vulnerable groups

As mentioned in the literature study, vulnerable groups often encounter additional barriers to access FP services. We identified a number of different groups in the three countries that may be labelled as 'vulnerable' besides unmarried people and these will be discussed in this section.

4.3.2.1 Unmarried people

Unmarried people in DR Congo are taught that abstinence is the only right method for them. HIV is discussed but it is a taboo to discuss the use of contraceptives. Sometimes unmarried people are denied access to condoms, especially when they are younger than 18. They do however have access to methods at the pharmacies. Both faith-based beliefs and the law play a role in this, as by law, minors are not allowed to have sex and therefore offering condoms or other methods is unlawful. Furthermore, some Christian staff see it as their duty to explain to unmarried clients that abstinence is better.

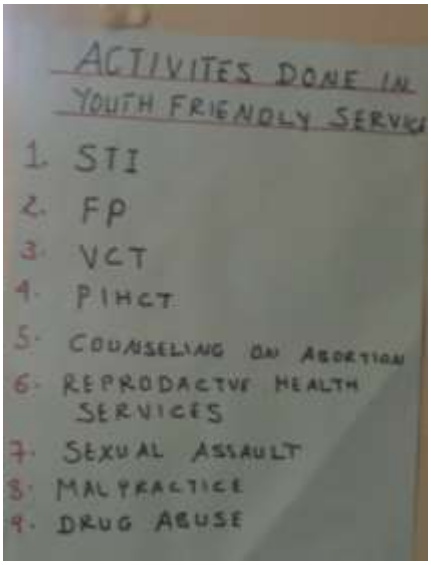
In Ethiopia, girls are often too shy to access FP services. At one of the partner organisations, however, they do explicitly offer youth-friendly services and the staff knows techniques for interacting with youth. Young nurses (peers) use stories of other unmarried people to show young clients that they are not the only ones dealing with FP topics. In other cases unmarried women ask young children or their boyfriend to access methods for them. In Malawi unmarried men mainly access methods through community-based distributors. CBDs however only provide one or two condoms at a time, whereas the staff of the hospitals can give more. Both hospitals in Malawi claim to be youth-friendly but they do not have many unmarried clients.

The importance of including youth is also illustrated by the following quote of a chief in Malawi: *"Youth should have access to contraceptive methods. This can help to reduce unwanted pregnancies. It is however hard for youth to get access as this community is very far from the hospital. It would be such a good solution if people from the hospital would come to our village to give counselling and distribute methods!"*

4.3.2.2 Vulnerable groups

Persons with disabilities are a vulnerable group. In different places, health centres are not wheelchair friendly. For example in Nkhoma-Malawi the hospital is not wheelchair friendly and people with a walking disability have even more difficulties than others in arranging transport to the hospitals/clinics: *PWD Malawi – "The only place where they [women with a disability] can get methods is in Nkhoma hospital. There are no distributors here. They however cannot walk to Nkhoma and need to find a bicycle (taxi) to get there. Transport is really the biggest problems and it would be helpful to have distributors."* (cf. annex 3). In Ethiopia, staff did not expect PWD to be in the clinic: "*Why would they need contraceptives?"* However in DR Congo, one nurse remarked "Of course they are a target group, they also get children". Some PWDs in Ethiopia and DR Congo are involved in a group that also provides FP methods.

In DR Congo pygmies have difficulty accessing the FP program and health care in general, as they are nomads and living far away from any health post. Furthermore, they often do not have money to pay for services offered in health centres. The partner-organisation in Komanda has focused specifically on pygmies, and recently a woman has adopted an implant.



Activities of the Youth Friendly Service room

In the government health centre in Biyo (Ethiopia) one treatment room was especially designed for providing services for youth (from 15 up to marriage). When youth register at the health centre, there is no need to explain the reason for coming. The youth wait in a shared waiting room (with clients from all ages) and are subsequently invited in the YFS room, which bears no special markings. In the YFS room, a young nurse (aged 24-27) first explains all the activities done in the YFS room, based on a poster (see pic). By this youths realize they are not the only one with such problems. The nurses use the youngsters' language (no medical terms). On average, 5-7 visitors a day come to the YFS room, of whom 3-5 come for contraceptives. For repeat prescriptions and activities outside the reach of the YFS room (e.g. abortion, infections, minor surgery, laboratory tests) the youth is transferred to another room at the health centre. The partner organisation EKHC Kuriftu supports this YFS room by providing counselling training for the nurses and by promoting it among HEWs, community leaders, teachers and youth leaders in HIV clubs. In the focus groups in a rural area (20 minutes' drive from the Biyo health centre), almost every unmarried person knew about the YFS room, although most of them said they did not visit it.

Box 3 - Youth Friendly Service room (YFS)

Sex workers are another vulnerable group. In Ethiopia they can go to a large health centre/hospital and just pretend to be married. In DR Congo sex workers have access to condoms in Nyamuhinga. However, clinics which require that the husband accompanies his wife make it hard for sex workers to receive counselling and contraceptives.

4.3.3 Referral policies

Health workers are well informed about the contraceptives they offer, hence most clients take these contraceptives. However, if something goes wrong (severe side effects) or if a beneficiary wants a treatment or contraceptive which is not available, the health worker refers.

Services that are typically found at the lowest level of the health system are condoms and sometimes pills. The next level adds injectable, pills and sometimes implants, Morning-After Pills and natural methods. At the third level, the extra contraceptive is implants and loop. For sterilisation (sometimes also implant & loop) people have to go to the hospital.

We found in Malawi that when a health worker found that a client had moral or spiritual questions concerning FP, she could refer the client to a pastor for further talks.

4.3.4 Alternative sources of PPM

Besides these health facilities, people can get access to PPMs in pharmacies, on the market and in mini-shops. This is slightly more expensive but close to the people. The disadvantage of these providers is that they may offer incorrect information or no information at all. Furthermore, there are other NGOs that offer contraceptives: Family Guidance Association, Marie Stopes in Ethiopia and in DR Congo especially organisations working with youth like Save the Children. In DR Congo there are also temporary HIV awareness campaigns where people get condoms for free, making the campaigns very popular among youth.

4.4 Changes in the services over time

In DR Congo the FP programs have only existed for 2-4 years. The availability of FP methods has increased and shifted from merely access at the hospitals to access as well at the health centres. In Ethiopia more services became available over the last few years, especially through a large effort of the government to increase FP availability and outreach to the rural areas with the help of HEWs.

Staff in DR Congo is more knowledgeable and trained on FP and acceptance of FP has increased among the community especially by the younger generations. There are two explanations for this. One is the information given by clinics on FP, where especially awareness raising with pastors has changed the attitude among Christians, and the other is the economic and social crisis which increased the need to reduce the number of children.

In addition, HIV has become more important in DR Congo and this has made it easier for unmarried people to get access to condoms, though it is still difficult to access other methods. There is still no real focus on unmarried people.

Lastly, in Malawi FP services are now more directed to couples instead of women alone. This means that men are encouraged to accompany their wives to the clinics and that couples are urged to discuss FP together. One result of this is that the secret use of FP methods by women has decreased.

5 Results (2): Perspectives

The focus of this chapter is on what people think about various aspects of FP. How does the community see the FP clinic? How does the staff see it? What ideas do people share about pregnancy prevention and how do men and women talk about this? Who do youth talk to about PPM? How do religious leaders think about preventing pregnancies? How do the staff think about providing PPM to their clients? These are the kind of questions that will be treated in what follows.

5.1 Community perspectives on the FP clinic

If we asked community members about their opinion on the clinic, most often the reviews were positive, people know where to go for FP services and people also know which other health services are offered. All clinics offer many other services, besides FP methods. Especially the care for mothers and children was mentioned as something positive. People mention an overall improvement compared to the time that the clinic was not there or not yet supported by the partner organisation (DR Congo, Ethiopia). Besides a place for health care, (mobile) clinics in Malawi are seen as meeting places, also used for trade and social interaction. On rare occasions, community members complained about services offered in the clinic. In Malawi: '*They will say I am not allowed to have more children', 'If I go, they will test me for HIV, so I don't go'. In Ethiopia:* '*They do not take time for me',* and '*A private clinic is much better'*. Also some people in Malawi do not trust the clinic, since they provide FP services which can cause permanent infertility.

The Christian identity of (workers in) the clinic, does encourage some people to come or to be open to the information the partner organisation offers. We never heard that people refused to attend the clinic because of its religious identity.

5.2 Staff perspectives on the FP clinic

Staff members also shared their opinions with us and mentioned shortcomings in staff materials, hygiene, time for counselling, accessibility and availability as problems encountered. Field staff in Malawi and HEWs in Ethiopia complained about unfulfilled promises as they were promised a bag and umbrella in order to do their work properly, but they did not receive it. Another staff member in Malawi also complained that while she is expected to pick up tallies in the hospitals and travels to that place, the tallies are often not there. In DR Congo, *relais communautaires* complain that they do not get anything from their work. While they are volunteers, they have to pay all their travelling (in order to create awareness within the community) expenses themselves. On the other hand, staff members are quite motivated to work for the clinic and usually like to do their jobs. In situations where income directly depends on prescriptions, counselling is not attractive for staff as it takes much time but does not generate income.

5.3 Community perspectives on the FP information campaigns

Besides improving the clinics, the partner organisations also improve FP acceptance and knowledge in the society through information campaigns. Especially if they cooperate with already accepted networks (church, government) the community is very positive about the information provided by the FP program. Participants review the trainings as very useful and this is noticed even by the Ethiopian government: both Jimma Medan Acts and EKHC Kuriftu have been rewarded with many certificates to encourage and praise the work they did within the government health system. Also youth group leaders are positive: "*Jimma Medan Acts means more for Jimma than the University,*

since they serve the vulnerable groups by giving them resources and information." Often community members are positive without specifically knowing what the partner organisation is doing.

5.4 Community perspectives on the use of PPM

5.4.1 Reasons for using PPM

The number of children viewed as ideal differs per country and between women and men: 2-3 for men and women in Ethiopia, 3-5 for men in Malawi, 2-3 for women in Malawi and 3-5 or 3-6 for women and men in DR Congo, respectively. Because of the global social and economic crisis, the rapid population growth and, in DR Congo, the instability caused by conflicts, people want fewer children.

- Health is mentioned as an important reason to choose for FP in Malawi and DR Congo, but is mentioned remarkably little in Ethiopia. The health of a woman is improved by FP as longer time between pregnancies gives the body more rest, and the woman loses less blood. This causes a woman to stay young and beautiful longer. Furthermore, the health of the children is seen as important, where fewer children means more food and money per child and more time to care for them.

- Economic reasons are mentioned as important reasons in all three countries such that there is enough food to feed the children and enough money to give them an education. In Malawi and Ethiopia education is free except for books, but better education in private schools is expensive. In DR Congo parents have to pay for education. An argument in Malawi is the quantity of land children can inherit.

- When children go without food and education they are felt to be causing problems in society. They will leave the household to go into prostitution, become criminals or street children (Ethiopia) or join the rebels (DR Congo). In Ethiopia some people feel ashamed towards others if they have many children, because they consume too big a part of the government money, or degrade the Ethiopian people by 'producing' street children. In Ethiopia and Malawi, prevention of population growth is an argument for FP.

- Other arguments are that parents with fewer children have more time to do community work (obligatory by Malawian government). Also in DR Congo, people mention that with fewer children, women have more time to be involved in other community- or income generating activities and develop themselves.

- For unmarried people, the main argument in favour of PPM is that it prevents unwanted pregnancies which would interfere with education and lead to social stigma for the girl.

5.4.2 Reasons against the use of PPM

There are cultural reasons why people do not use FP methods. In Malawi, for example, a higher number of children adds to the prestige of the man. In all three countries, when a woman bears no or only few children, her husband might leave her to search for more with another woman. People say that it is better to have many children as children might die (Malawi) and people say *"In Africa we get a lot of children, it is the white paternalist who tell us to have fewer children".* In Malawi it is also mentioned that sex is nicer with a pregnant woman and in Ethiopia that contraceptives diminish sexual desire or make it harder to enjoy sex. There is also a perception that a woman who cannot get

pregnant is more likely to have sex with other men and so might prostitute herself (DR Congo, Malawi).

Some do not worry that they may not be able to care for their many children: "*children belong to the community;, if one cannot take care of one's own children, there are always other people who can, so why should we use FP?"* (DR Congo, Malawi).

Religious reasons against the use of FP are mentioned as well. Within a marriage, using modern contraceptives is sometimes seen as rejecting Gods' gift (Ethiopia). God has a plan for each child: "*You know the family of Jacob? If Josef, his nearly lastborn, would not have been there, who would have saved the whole family from the famine?"* (FGD with church women Uvira). An old community leader in Ethiopia said: "*I thank God that I and my wife never had to use contraceptives*". Especially Muslim women feel like their main aim is to expand the generation (Jimma Ethiopia).

5.4.3 PPM & Gender roles

5.4.3.1 In general

Gender roles influence the day-to-day lives in the countries we visited. Women are usually active in many small tasks close at home. Taking care of children is one of their main activities, although they are often also active in income generating activities. Men are responsible for bigger tasks, like building houses, heavy agricultural activities in the field and deciding on expensive purchases. To continue these activities, people want both sons and daughters. In DR Congo daily activities of men recently changed by the unsafe circumstances in rural areas, which causes them to be less busy.

Inequality in gender roles are, besides differences in activities, stimulated by age differences between wife and husband (especially in Ethiopia) and differences in responsibility. Males are usually the ones that are seen as older, more rational and wiser, so they are able to make the decisions. They are also considered as the head of the family who should be obeyed by his wife. Health care is the responsibility of women: care for children and their own (maternal) health. If a woman has HIV, it is often not the men who blame themselves about that (DR Congo). In Malawi a new trend is that HIV is considered and approached as a family disease, instead of a mothers' disease, which increases gender equality. This family-focussed approach is a very positive trend, since it also encourages partners to discuss FP together.

These posters from Malawi (l) and DR Congo (r) let people realise that women can have a contribution to the community in more ways than only by getting children

5.4.3.2 FP in marriage

Since men have the final word in FP within a marriage, there are many women who use an FP method secretly, because they are afraid their husband would not agree - 50% in the North of Malawi and in Minembwe. Husbands in these areas do not accept FP and may fear that if their wives use contraceptives, they might also sleep with other men. We found in Ethiopia, Komanda and the south of Malawi that secret use is condemned by both church and community as it is wrong to lie to one's husband.

Communication within marriage about FP is stimulated by the partner organisations, for example by encouraging men to accompany their wives to the clinic. If there is communication about FP within a marriage, men are often more conservative and women more in favour of using contraceptives. In DR Congo the women know more options than men, but in Malawi and Ethiopia the knowledge on FP types is equal. Couples usually start speaking about FP after the first child (or son) is born. Initiatives such as marriage training by churches, encourage them to plan their family well. Just before and after sex and at the time education fees have to be paid are considered good times to bring up the subject of contraceptive use. A chief in Malawi argued that having a good marriage stimulates good FP use: "*FP has to do with how people think about marriage. People need to know that marriage is until death and that you should stay together. If people divorce easily they will also not think about FP".* Arguments in favour of FP are for women mostly health-motivated, whereas they use mainly economic arguments to convince their husband about using FP. Men are more easily convinced to use FP if there are male role models that also use FP. Once a husband decides to use contraceptives, the wife selects the most suitable method.

In DR Congo men are encouraged to come to the clinic with their wives

5.4.3.3 FP before marriage

For couples that are not married, men frequently take the responsibility to use a condom. In all three countries we heard from boys that girls are not always willing to use a condom, since it irritates during sexual intercourse and they do not want to communicate the expectation that the boy has an STI, or that the boy should think that she has an STI. Most boys underline the usefulness of a condom. The difficulty is that men have easier access to FP methods (since unmarried girls are very shy and not willing to go to the clinic for fear of being seen as a prostitute) but women carry the largest burden if no contraceptive is available. The girl will, in most cases, be blamed for a pregnancy, not the boy. However, in DR Congo boys talk about the risk that the family will accuse the boy and if the girl is under 18, he can be put into prison. Moreover if a girl gets pregnant, sometimes the boy takes responsibility and they start living together or marry.

5.4.4 Side-effects

For many people, the side-effects of contraceptives are a reason not to use them. In an FGD with women leaders in a church, there was a discussion whether contraceptives were acceptable. One woman said *"It's not a sin; it's just the consequences that are problematic. I used pills but I had big problems with them. Now I use an injectable, this works for me now"*, but another woman said: *"I*

would like to use contraceptives, but a new one, which is good, with fewer side effects. Do you know one? Not a pill or injectable!" And a third woman remarked *"There was a woman who used contraceptives, she used Depo for six months. Then she got pregnant, but the embryo nestled in her tube, and she had a miscarriage. After that she never got pregnant again",* and a woman summarised *"some women are in favour, some are against, but side effects are not good for anyone".*

This discussion illustrates the problems associated with using contraceptives. Getting sterile is the biggest fear, and many women know one or two stories about women who were not able to have children after using a contraceptive method. For people who have just overcome the barrier of faith to using contraceptives, stories or experiences of negative side-effects can become another barrier again. For every method, people can mention numerous side-effects, from trouble with their period, nausea, changes in the body (getting fatter or thinner) and tiredness to less fun with sex, getting pregnant without wanting to or becoming sterile.

When sharing this with staff of an NGO, a staff-member remarked that there are no side-effects and that many people do not know about the methods. This might be true, but hence, the image of the contraceptives is created. A staff-member in DR Congo) said that people often go to pharmacies to get contraceptives (because it is cheaper, closer or more confidential) and that in pharmacies people do not always give the right information. He said that in pharmacies it is possible to get an implant, even though there is no one qualified to put the implant in the arm (DR Congo). According to him this is the main cause of side-effects. Even so, staff admit that they see the side-effects of certain methods, and in Malawi clinic staff once told that the quality of pills they have is bad. Even though a lot of side-effects are associated with the injectable and the implant, still it is the favourite contraceptive method among the people we met in our research.

A reason mentioned by different organisations for the side-effects of the methods is also that women sometimes do not follow-up their appointments, so they do not take a new dose of the injectable or do not come to get a new series of pills. Clients also say that this is a problem, and they explain that they are often too busy with many other tasks, causing them to forget certain things.

5.4.5 PPM & Religion

5.4.5.1 Role of religious leaders

All partner organisations we visited have a Christian identity. The beneficiaries are from all religions: Christian, Muslim and traditional religions. In some places in DR Congo and Malawi, religious leaders condemn the use of modern contraceptives, or are silent about it (cf. 5.4.2). However, a difference could be seen in one place in Congo where church leaders were targeted in the awareness campaign of the partner organisation, which convinced them of the value of FP for adults. In Ethiopia and the north of Malawi most Christian religious leaders start to accept the use of (some types of) modern contraceptives. The attention has shifted from multiplication to care. *"If the family is not healthy and wealthy enough, the church might also fail in being a good church. You should be able to take care of the child and to let it grow up in good conditions to glorify God."*(Orthodox priest Ethiopia). In these areas, Christian leaders start to practice FP in their own marriages by having only 2-3 children, showing that they can be good Christians, even by having a small family. On the other hand, the less educated people stick to the old prescriptions and still consider the use of FP as a sin (Ethiopia). In

areas in DR Congo, where religious leaders do not speak about modern FP or condemn its use, many people do use FP even if their church does not support it.

5.4.5.2 Churches focus on marriage instead of pregnancy prevention

Some churches want to be actively involved in their members' marriages. They require HIV tests before blessing a marriage and they offer marriage trainings. During these trainings, they do not discuss FP openly, but they ask health workers to give a presentation (DR Congo) or to be the contact person for couples with questions related to FP (Ethiopia and Malawi). Church leaders in Komanda told us: "*Because Ushindi is a Christian organisation, we can listen to them*. *They can say things to our church which we as pastors can't say*". Also they aim to shift the focus from FP to 'having a good marriage'. This open attitude of church leaders towards good marriages and a well-planned family encourages couples to use FP. Partner organisations that train and inform religious leaders have a potentially huge audience: all the church members. In the debate around FP for *unmarried* people however, there is mainly embarrassment. Most churches ignore the problem and just preach abstinence; others recognize it but do not know what to do.

5.4.6 Staff perspectives on the provision of PPM

Some people see the use of modern contraceptives as a sin (especially people with less education in Ethiopia), but less sinful than having children and not taking care of them. The recent (economic) crises and population growth result in scarcity which makes it impossible or irresponsible to have too many children. This is also the reason that staff of the partner organisations do not hesitate to provide married women with modern contraceptives. In DR Congo the focus is shifting from being sinful by using FP to being sinful by not using your free will and knowledge given by God. "*You don't have to fill the whole earth with your own family.*"(unmarried girl, DR Congo)

5.4.6.1 Religious objections to specific method

In Ethiopia (Kuriftu) certain contraceptive types are not accepted for religious reasons: sterilisation (since generations should be continued), withdrawal (based on the story of Onan in the Bible), Morning After pill (seen as abortion) and condom (except within a marriage of two persons with different types of HIV). These methods are provided in the clinic, but by emphasizing the accepted methods during the training of the clinic staff (and being silent about the wrong methods) the accepted contraceptives will be used more. The organisation sees this emphasis on good methods in trainings as a way of serving God. In Malawi religious leaders condemn the use of a loop, since it kills a fertilised egg. This does not influence the staffs' willingness to provide the loop, but people did not want it and the available loops passed the expiry date. In other places, however, staff aim not to steer the choice of clients (in the direction accepted by God) but to give right and objective information. The clients can decide themselves whether the religious arguments are important enough for them not to choose for these options (Jimma, Ethiopia). A very few community members argue that God gives us a mind to use natural FP methods, so modern contraceptives are unnecessary. No staff member of the partner organisations agrees with this argument, however, because they consider most people as not disciplined and intelligent enough to prevent pregnancies by natural FP methods.

5.4.6.2 Providing PPM to unmarried people

For unmarried people, the attitude of staff differs per place. Most churches preach abstinence. In case of abstinence, no contraceptive is needed for unmarried people. "*If you are using something like that (contraceptive) in our church, you can't marry*" (pastor in Uvira). Some health workers

believe that by advising abstinence instead of providing contraceptives, there will be less premarital sex. In DR Congo this is indeed practised (minors are legally not allowed to take condoms from the clinic) but in Ethiopia this is more theory than practice, because staff members do not mention abstinence for young clients in role plays. In Malawi this is not at all influencing the willingness of staff to provide FP for unmarried people. The staff feels their responsibility is to inform, counsel and make FP accessible; not to promote moral thoughts.

5.5 PPM & Government influence

The governments of Ethiopia and Malawi provide contraceptives free of charge and provide some posters/education materials for the hospitals on FP. In DR Congo FP is in the basic health care package which shows that the government is in favour of FP, even though the government does not provide the means to run an FP program. Health workers in DR Congo and Ethiopia, trained by the government and the NGO, work within the existing structures of the government. This implies the risk of unexpected staff mutations. In Malawi, the hospitals visited were owned by the church and staff were employed by the Synod of the Church of Central Africa Presbyterian. Since the synod was not able to pay the same salaries as the government, it had difficulty recruiting enough staff.

In terms of policies, we noted in Ethiopia that the government was encouraging the use of long-term contraceptives and health workers did their best to comply. The fact that Ethiopian health extension workers could speak about FP during home visits demonstrated the value of government support for the promotion of FP.

Concerning policies with regard to adolescents, minors (below 18) in DR Congo are legally not allowed to have sex. It is therefore officially not allowed to give minors condoms as it encourages them to do what is not lawful. However, condoms are given for prevention of HIV/AIDS.

5.6 Changes in perspectives over time

The more intensive programs resulted in bigger change in perspectives in the community especially for Christians due to FP awareness raising with church leaders. In Ethiopia, the moral on FP and sexuality has changed and results in a different perspective between generations and educated and uneducated people. Due to a lack of resources (mainly related to inflation) people are also more cautious on the number of children they want to have. *FGD married women – "If I would have known about modern FP 3 years ago, I would have had 2 kids less and a happier marriage*". The perspectives of churches became more tolerant towards FP. Also in Malawi and DR Congo, there is a difference between generations in terms of the size of families and the desire to have a large number of children. Young people in Malawi nowadays are more concerned about the scarcity of land as the population there is growing fast. In general people have more knowledge on FP. Furthermore, although the programs before focused on the women, it has become more common to involve men and the emphasis has changed from individuals to families. The perspective of most churches has shifted from the message of multiplying to the call to take care of your children.

6 Potentials & Challenges

The present research has identified a number of initiatives that were working well. We describe them here in some detail in the hope that they will inspire others to imitate them. Of course, one needs to be aware that what works in one setting may not work exactly the same way in another set of circumstances. It is always good to first do a pilot to test the viability of an idea in a new situation.

We have also identified some problem areas that represent serious challenges for the advancement of FP in Sub-saharan Africa. Some of those are straightforward and simply require attention and investments; others are complicated and require further study.

6.1 Role Models

We were happy to meet community leaders and religious leaders who were willing to advocate for the need for family planning within marriage. Some even went as far as walking the talk i.e. limiting the number of children they produced, thus acting as role models to their communities. Concerning sexuality among youth, most of these leaders would say that abstinence is the best option for them, but would be willing to discuss the issue with young people and make sure they knew how to protect themselves if they did have sex.

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.

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 partner organisations can show leadership and influence a wide audience in this way.

Recommendations

1. *Develop programs to specifically address community and religious leaders, both men and women, to gain their support for family planning.*

2. *Encourage and equip staff of partner organisations to speak about FP in churches.*

6.2 Promoting and delivering FP through existing networks

In all three countries visited, effective distribution of PPM was possible through existing networks of either the government or NGOs. In Malawi the Uchembere program for safe motherhood reaches a lot of people who would have considerable difficulties reaching a hospital in order to obtain information about PPM. In Embangweni, the network only distributed condoms and pills in the villages but mobile clinics provided injectables and implants as well. Clearly, there are many possibilities for increasing collaboration between the FP program and the Uchembere network.

In Ethiopia, the inclusion of FP in the collection of subjects the health extension workers (HEWs) discuss during home visits is a very strategic move and NGOs can support the HEWs to be trained and equipped for this aspect of their task.

In Congo, investing in the primary health care system and the *relais communautaires* to support the delivery of information about FP and of contraceptives was an effective intervention that met a considerable need.

Recommendations

3. *Invest in already existing networks, in particular in the training of existing extension workers who visit families at home and can speak about FP and distribute contraceptives.*

4. *Include FP in the objectives of the Uchembere program to facilitate collaboration with the local FP program in all of Malawi.*

6.3 Encouraging dialogue between partners

We have seen several examples of how FP programs actively encouraged men to join their wives in the counselling sessions. In Malawi, couples did not have to wait in line with the majority of women who attended the service alone. In DR Congo, one clinic would only council women if they came with their partner. Churches that present dialogue about FP as part of *good marriage* and who condemn secret use of PPM do the same thing (cf. 5.4.3.2). Although one might ask if this always results in the decision the woman would have preferred, there are obvious advantages to taking a joint decision. Dialogue between life partners about sexuality will also facilitate speaking about it with children later. Although FP services should never be rigid or dogmatic about counselling only couples, our findings suggest that there is good reason to think creatively about policies that encourage men to participate.

Recommendation

5. *Think creatively about policies that encourage the participation of couples in FP counselling and help men and women to have dialogue about sexuality and FP.*

6.4 WSWM – youth groups – peer educators

The initiative to offer young people access to the WSWM software and go through sustained teaching and awareness raising about sexuality issues clearly met with success (cf. Box 1). Since it created the only place in town where young people could access computers for free, both students and teachers enjoyed the opportunity. Although we could not ascertain the impact of this program in our research, it likely had benefits both in terms of pregnancy prevention and of HIV-prevention. Offering this information should be accompanied by provision of condoms and other methods of pregnancy prevention as appropriate. The teachers made sure that the discussion of choices with regard to sexual activity included the fully valid option of abstaining if that felt more comfortable.

Connected with the above initiative was the formation of youth groups where life choices and sexuality could be discussed. Our observations suggest there is a lot of scope for such groups. These can very well be run by churches but also by schools or through a health program. This approach also involves the training of some youths as peer educators.

Recommendation

6. *Work with existing youth groups and form new ones to discuss issues of sexuality and life choices including pregnancy prevention methods. This can be done in churches or in schools, but also through health programs.*

6.5 Condom distribution

The simple idea of setting up a distribution point ('condom corner') where condoms could be easily obtained for free without difficult questions being asked clearly worked for young people in the capital of Ethiopia. In many places, staff felt uneasy about distributing condoms without a 'message' (Ethiopia), limited the number of condoms handed out each time (Malawi), or felt hindered by legal restrictions (DR Congo). 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. Prisma has said earlier (2009) that it seeks to stimulate a dialogue with partner organisations in which Christian principles play a central role. This is clearly an area where such a dialogue holds a lot of promise, since Christians in the Netherlands struggle with similar problems.

Condom corner (Addis) where young males could easily come and take away free condoms without counselling

Recommendation

7. *Encourage dialogue between Christian supporting organisations in the Netherlands and partner organisations in Africa on the subject of adolescent sexuality.*

6.6 Youth friendly service room

The Ethiopian initiative for a Youth friendly service room (cf. *Box 3*) was very successful. It was characterised by removal of stigmatising labels, avoidance of embarrassing questions, the young age of the staff involved and the use of appropriate language and reassuring clients that their questions are not unusual. The minimum age had been set at 15 years but this can be varied according to the circumstances. The success of the service was evident from the frequency with which it was used and from its good reputation which was found to exist several kilometres away.

Recommendation

8. *Translate the concept of the Youth Friendly Service room to other settings.*

6.7 Posters

Many posters on FP exist (cf. annex 4). A good poster uses local language and telling illustrations. A poster should not explain FP options that are not available in the clinic where it is exhibited. Posters have an important function in consultation rooms but their usefulness in waiting areas is perhaps underestimated. A so called Dummy poster (cf. annex 4), to which actual samples of available PPM are attached is simple but surprisingly effective.

Recommendation

9. *Encourage FP staff to make Dummy posters which display all PPMs that are available in a given clinic.*

6.8 Side effects

A problematic area is the whole question of side effects. Side effects, mostly of hormonal methods, are discussed by many either quietly or openly and the popular understanding of this issue heavily

influences peoples' choices with regard to FP. Yet, preciously little objective knowledge is available about these side effects to either the staff of the FP programs or to the clients using FP. Our data demonstrate an urgent need for more information about side effects, answering such questions as: What are the side effects associated with a given method? What is the risk of side effects for a given method? What personal factors modify that risk? What can be done if side effects occur? Is there anything staff or clients can do to minimise the risk of irreversible adverse effects?

Recommendation

10. *Collect scientific information on the risk of pregnancy and the risk of side-effects associated with each pregnancy prevention method, including natural methods, and disseminate this to FP programs in a simple format that can be used in training of staff and in educating the public.*

6.9 Good implementation practices

Our findings illustrate once more what every seasoned health manager in Africa knows, namely that to operate an effective, well-oiled program, the basic ingredients such as training, supervision, protocols, incentives and materials require continuous, energetic and loving attention.

Recommendation

11. Ensure that every FP clinic that a partner organisation supports has staff that is adequately trained in counselling and is qualified to deliver contraceptives such as injectables and implants.

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ANNEX 1 Literature Study

1.1 General theoretical focus

1.1.1 Why is FP important?

As the World Health Report (WHR, 2005) reports that the most common causes of maternal mortality in developing countries are unwanted, mistimed and unintended pregnancies, we feel the need to better understand the challenges of FP programs. Contraception is needed in order to decrease maternal mortality by preventing unintended pregnancies and related unsafe abortions. This has been documented for example in Ethiopia by Beekle & McCabe (2006) and Bogale, Wondafrash, Tilahun, and Girma (2011). Other reasons for promoting contraception include the prevention of sexually transmitted infections through barrier methods and limiting population growth which results in more resources and better education for the children that are born.

1.1.2 FP services and struggles

Many organisations, however, struggle to successfully promote the appropriate use of FP methods. Similar to the framework of EngenderHealth we acknowledge that these struggles and challenges may arise from the levels of: (1) *the individual* - those people in the age of reproduction that might want to make use of FP services. This is the target group of the POs and from the side of these community members there may be all sort of reasons for why they do not make use of FP services; (2) *the service provider/PO* - if POs offer low quality FP services (which holds many aspects such as counselling, access and acceptability), it is likely that community members will not make use of these; and (3) from *policies/or the social context* - both the community members as well as the POs are embedded in a social context; i.e. cultural and religious beliefs, social norms and values, and policies. We cannot understand the behavior, decision making or attitude of community members or POs without taking account of this context (EngenderHealth, 2003). This is especially true for the African context where more often than in Western society, people have their identity within the community and the family. This means that individuals may be less aware of their rights and how they can exercise these as compared to Western society. In Western societies people may or may not choose to exercise their rights regardless of what others (such as family) may think of them. This is however not the same for individuals in most Sub-Saharan African settings. In this study we focus on the practices, perspectives and potentials of POs in relation to these three levels whereby we consider (1) the community member (potential users of FP services) and (2) the PO (the service provider) both in their social contexts (3). Furthermore, we focus more specifically on issues that arise from religious beliefs, and issues that are specific to young, unmarried people. In many studies, issues of unmarried people are generally underexposed because religious and cultural beliefs do often not acknowledge or approve of sexual behavior of unmarried people (Akwara, Madise, and Hinde, 2003).

1.1.3 EngenderHealth

To understand challenges of FP programs of POs we need a theoretical framework that gives understanding of issues we might encounter on all three levels. As base for this theoretical framework we make use of the tool kit of EngenderHealth (2003) which considers five basic elements/conditions that support access to contraceptives and informed and voluntary decision making:

1. Service options are available;
2. The decision-making process is voluntary;
3. Individuals have appropriate information;
4. Good client-provider interaction, including counselling, is ensured;
5. The social and rights context supports autonomous decision making.

We will use the five points of EngenderHealth as our main framework and will supplement this with key points from several documents (e.g. Prisma, 2009; Cordaid, 2010) and articles (e.g. Beekle & McCabe, 2006; Cottingham, Germain & Hunt, 2012; and Varga, 2003). In the following section we aim to explain the challenges that arise from the community members' level and the PO's by which we consider the third level: the social context. Lastly we explain what issues concerning sexuality and FP services apply specifically to young and unmarried people.

1.2 FP at the level of community members

1.2.1 Personal characteristics and vulnerable groups

Several factors at the level of community members may explain a lack of informed and voluntary decision making, or even just a community member's choice not to make use of FP. First of all, personal characteristics (such as gender, marital status and education) have an influence on an individual's informed and voluntary decision making and on the degree of support that this individual receives from his or her social network (Mathe, Kasonia and Maliro, 2011). This is especially true for people living at the margins of society, such as refugees, internally displaced women, persons with disabilities, persons infected with HIV, or those from religious or ethnic minorities (Cottingham, Germain and Hunt, 2012). Furthermore, homosexual people and commercial sex workers are as well often ignored or stigmatized (Cordaid, 2010; Prisma, 2009).

Women and unmarried people commonly face similar difficulties. African societies are often male dominated. This means as well for relationships that it is generally the male who makes decisions regarding FP issues. Women often have little access to contraceptive methods as there is a strong relationship between gender ideals and sexual risk-taking. African women commonly gain respect by being sexually available to their partner, by giving him sexual decision making authority, by being sexually faithful, by bearing children or by avoiding pregnancy before a marriage took place. However for physical, cultural, social, economic and political reasons, women have generally less decision-making power within relationships. This makes it hard for them to protect themselves from unwanted sex, transmission of infections, violence, or simply from gaining information about FP (Prisma, 2009; Varga, 2003). Not just women, but especially unmarried women (and men) often have little access to FP education, services and methods. As they have a specific need in terms of FP we focus on them and will study how the POs support their informed and voluntary decision making and what challenges they have to overcome. In this respect we will pay specific attention towards gender roles as men often make decisions as to what methods will be used (if used). The use of contraception is rarely negotiated or discussed between partners and it is often considered the responsibility of women not to get pregnant, although they cannot decide why or how. We should thus realize when targeting women that it is often the men who decides in the end and it is therefore necessary to support women and to encourage dialogue between partners (Bogale et al, 2011; Doctor, Phillips and Sakeah, 2009; Mathe et al, 2011; Prisma, 2009; Varga, 2003). Additionally, some religious teachings may be more open to teaching sexual health and the use of FP methods than others. Some Christian denominations for example encourage autonomy for women, individual

agency and may hold certain values that are positive towards use of contraceptive methods (Doctor, Phillips and Sakeah, 2009).

1.2.2 Knowledge on FP

Second of all, a lack of knowledge also challenges the decision making and behaviour of community members. If people have more information, it often means they will also make more use of FP methods. Also, people who have more information tend to behave more risk-adverse, and will be less likely to engage in unprotected sex (Beekle and McCabe, 2006; Bogale et al, 2011). A lack of knowledge exists around which methods are most suitable, how to use such methods, and what the possible side-effects are of contraceptives (Mathe et al, 2011; Varga, 2003; Yeatman and Trinitapoli, 2008. Some people for example fear irreversible changes to their bodies such as permanent infertility, physical damage, cancer or damage to future offspring. We want to emphasize that the fear of side-effects cannot simply be dismissed by arguing that people have a lack of knowledge. These fears are a reality to them and might be true as the quality of contraceptives could be relatively poor.

1.2.3 Information sources for FP

Thirdly, we are interested as to where people receive information on FP. People might gain knowledge about FP methods from all kinds of sources. Churches for example may provide information and education to their members about reproductive health issues. Religious leaders generally have major influence on church members in terms of sexual morality and practices. Especially where literacy is low, local religious leaders possess significant authority in the community. This can of course be positive as well as negative in terms of SRHR as some religious schools of thought may be more open to teaching sexual health and the use of FP methods than others. At the same time the church functions as a social community where frequent interaction between people is likely to foster the discussion between church members on issues related to sex and contraception (Doctor et al, 2009; Yeatman and Trinitapoli, 2008). Furthermore, norms and values are often shaped within religious communities and give people directions about the autonomy of women, about individual agency, sexual morality, family size, and more specific about the use of contraceptives. Besides religious communities and religious leaders, family plays also an important role in shaping sexual morality. Decisions regarding FP are often made by other people than the client, especially when the client belongs to a vulnerable group. Additionally, NGOs that offer FP programs often provide information through all sorts of media, such as posters, radio, dramas, and community based activities, in multiple languages (Jacobstein, 2013). Lastly, we should keep in mind that individuals may hold a number of reasons for the use or no use of FP methods. These reasons are shaped by the social environment, by norms, values, expectations of the family, and religious teachings. No individual, especially not in African societies, is a standalone.

1.2.4 Policies

As was mentioned in the introduction, in many African societies individuals are less aware of their rights and how they can exercise these as compared to Western society. As such, decision making of clients regarding FP methods is often influenced by a range of external factors, with a specific influence of relatives. Additionally, small churches as well have an influence on these matters as they can encourage or discourage use of FP methods (Cordaid, 2010). From this we should learn that we cannot simply encourage or rely on individual rights when it comes to Family Planning. It is matter to understand that especially in the African context people are part of a wider community, one which is

shaped by family, by the church, and by the government. Prisma (2009) teaches us that in some countries sensitive issues regarding FP are also sensitive topics in government policies. Furthermore, Western representatives are often regarded with suspicion because of their (often) liberal values concerning sexuality. Organisations working with FP programs have to find a balance concerning how far they can go with or against governmental laws. It might be that simply the sharing of information about sexuality and contraceptives is illegal. This makes it hard to create awareness and openness concerning FP (Prisma, 2009). Each organisation running a FP program, and also the ones evaluating such programs, should be aware of the political environment and how to deal with this.

1.3 FP at the level of POs

1.3.1 Physical and social access

From the level of POs a number of challenges may arise as well. People may have difficulty accessing FP services physically as well as socially. Prices of contraceptives, distance, language issues, and information are examples of physical barriers. Bad counselling, a lack of confidentiality, the requirement for authorisation by a spouse or parent, a lack of choice in terms of various contraceptive methods, inadequate training, and laws that restrict access to services for specific population groups are more social barriers (Cordaid, 2010; Cottingham et al, 2012; Jacobstein, 2013; Mekonnen and Worku, 2011; Yeatman and Trinitapoli, 2008). Especially vulnerable people, such as people with a disability, have trouble getting access to FPservices (Prisma, 2009). Furthermore, access to information and services is often restricted due to a lack of acceptability, which is commonly related to the dominant norms and values in society (Yeatman & Trinitapoli, 2008).

1.3.2 Availability

Secondly, not all FP methods may be available to everyone and due to a low quality of services people can be discouraged to make use of FP services. It is good to realise that if a high demand for limiting exists, this does not mean that there is also a high use of contraceptives.If people want to make use of contraceptives, even if they have the right information and support, sometimes (certain) contraceptives are not available. In some countries in Africa stock-outs of contraceptives are even a chronic problem. In Kenya for example, one out of five women who do not want another child do not use contraception because of this. Commonly this is true when implants and injectables are not available. Sometimes alternative inferior contraceptives are available at low prices, but these can cause serious harm to peoples' health (Cottingham et al, 2012). It is noteworthy that on the other hand, despite shortages of health personnel, poverty and other resource constraints, Malawi did make female sterilization widely accessible (Jacobstein, 2013). Thus, availability and quality of contraceptives have a likely but not necessary relation to factors such as poverty and other low quality health services. We think that governments and organisations should work actively on making contraceptives equitably accessible. Quality of services may be low due to a lack of privacy and confidentiality (Prisma, 2009), but also due to a lack of female or male service providers, or a lack of choice (Mekonnen & Worku, 2011).

1.3.3 Adequacy of staff

Third: it might appear that staff lacks the knowledge or skills to provide the desired service. Communication and analytical skills are for example crucial aspects of successful service provision (Bogale et al, 2011; Cordaid 2010; Mathe et al, 2011). Also, when staff is not confident in discussing FP topics, it is also likely to (negatively affect) clients' decision making on FP. Staff needs to make

sure that the environment is one of openness, confidentiality and honesty in order to successfully provide services. Additionally, staff may simply not support the service that they are required to give, or to whom they have to give it. If staff does not approve of clients decisions and perspectives they are not able to support their clients well. Clients need a safe and accepting environment in order to ask for advice and make use of contraceptives (Cordaid, 2010; Mekonnen and Worku, 2011). Cottingham et al (2012) as well find that '*An apparently increasing number of health-care providers refuse to provide various sexual and reproductive health services including contraception on grounds of conscience, because they disagree, for personal or religious reasons, with the use of contraception*' (Cottingham et al, 2012, p.4). Clients are likely to notice such attitude of health-care providers and are likely to make no more use of their services. Especially religion-based organisations need to be conscious of the potentially negative association of FP and religion in the minds of their clients which might endanger such a 'safe and accepting environment'.

1.4 Youth and FP

1.4.1 Need to include youth/unmarried people

Finally, youth are hardly included in studies on FP. Most research focuses instead on decision-making of married couples and parenthood. We may again notice that reproductive behavior of youth is highly underexposed by researchers (Varga, 2003). Ironically it is found that there is a particularly high unmet need amongst unmarried women. Studies on FP and SRHR often only include married women of reproductive age, who do not want to become pregnant. These young women often lack information and/or cannot get access to FP services. Cottingham et al (2012) found that approximately half of all sexually active young women (aged 15-19 years) in Sub-Saharan Africa are unmarried. Only 41% of those women make use of a modern contraceptive method. As it is more likely for this population to have unprotected and non-consensual sex, there is specific need to include them in FP programs. Moreover, both Beekle (2006) and Mekonnen and Worku (2011) show that couples that do discuss FP issues more often use contraceptives and have better understanding of each other's opinion and needs in terms of FP. Of course this relationship works two ways. Naturally, couples that are educated and have a higher income are often more open for discussion of FP topics. On top of that, Doctor et al (2009) also found that partners who belong to the same religion commonly have an idea of stability that may have an effect on contraceptive use. 'For example, if a couple's shared religion forbids the use of contraceptives, the couple will likely adhere to such a doctrine, whereas if each partner belongs to a different religion, couples may exercise different behavior related to childbearing' (Doctor et al, 2009, p.4.). When studying informed and voluntary decision making on FP, we should be aware of all these factors that influence gender relations and ultimately individual decision making.

1.4.2 Why they are not included

Messages regarding FP are often conventional and do not address the needs of young people (Cottingham et al, 2012). A reason for why the need of young people is often not met relates to taboos about sexuality of unmarried people. Cordaid (2010) for example found that in Malawi there is significant tension around teaching sexuality in Catholic schools. Some teachers are not at ease with the topic or it is not clear what they are or aren't allowed to teach about sexuality. It is necessary that these teachers receive support in terms of knowledge and skills which is likely to improve their confidence about speaking about sex and contraception (Cordaid, 2010). However, it is not only from the side of teachers that young people lack access to information. Parents as well

find it often difficult or unnecessary to teach their children about sexuality (Regnerus, 2005). Furthermore, FP services are often not 'youth-friendly' as they are not attractive to youth and do not meet their needs. It may also be that staff members have a negative attitude towards youth due to personal beliefs, but also due to a lack of skills and knowledge about what young people need. This discourages young people to make use of services as they feel embarrassed about sexuality (Cordaid, 2010). Another reason why many young people do not receive the information and support they need is that it is commonly thought that teaching sexual health to young people actually encourages sexual promiscuity, so it assumed better to tell them nothing at all (Prata et al, 2013). Other issues that young people deal with have to do gender inequalities – more or less similar to what has been discussed before. Young people often lack trust in their partner and the influence of peers can be decisive as to choices that young people make in regards to the use of contraceptives. Especially young women and girls are thus at risk because they often find difficulties in dealing with pressure of others, especially the partner (Cordaid, 2010, Prata et al, 2012). As mentioned before, we will focus specifically on the need of young people as they have the highest unmet need in terms of FP.

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ANNEX 2 Vignettes and role plays used

Vignette used in SSI Staff (C:N, E:A, K, J) & FGD staff (C:K; M:E)
Main themes: contraceptives, sexual morality, counselling
One day a girl of about 16 year old comes to you for counselling. She is very nervous and after a while she tells you that no one should know that she came to your health post. Her 10 year older boyfriend told her that he wanted to have sex and that if she wouldn't sleep with him, he would leave her. She tells you that she really loves him and that because it is really important to him she agreed to sleep with him. She is however afraid to get pregnant, but is also certain that her boyfriend won't take responsibility for using contraceptives. She asks you what contraceptives are best to use in her case.

- *What would be your first reaction if the girl had come to you?*
- *What would you advise her?*
- *What do you think of the decision of the girl to sleep with her boyfriend?*
- *Do you think a story like this is common in the area you live?*

Vignette for FGD unmarried women (C:N,U,K; E:A,K,J; M: E, N)
Vignette used for unmarried men: change gender in story (C:N,K)
Main themes: FP, sexual morality, acceptability, youth
Last Sunday you went to church. After the service when you were standing outside you heard two young girls having a conversation. The first girl told her friend that she has had a boyfriend for about 6 months and now they wanted to have sex with each other. She wanted to be sure not to get pregnant so she asked her friend what contraceptives she should use. The friend however reacted very angrily and told the girl that she should wait until she is married before having sex. She told the girl that if she would sleep with her boyfriend she couldn't be friends anymore.

- *What would have been your reaction if your best friend came to you and told you she wanted to sleep with her boyfriend?*
- *What do you think of the reaction of the friend? Do you agree, why/not?*
- *Why do you think the friend reacted so angrily?*
- *Who would you ask for advice if you wanted to know anything about sexuality or family planning?*

Vignette used for FGD unmarried men (E:A,K,J; M:N)
Main themes: FP, counselling, choice of options.
X is a 19 year old girl. She is single, very attractive and very popular. She had her first baby 18 months ago. The father is nowhere in sight and X wants to find a steady boyfriend.

Would you consider being her boyfriend?
X says she wants you to use a condom every time you have sex.
Would you accept?
What solution would you propose in this situation?

Vignette for married women (C:N, K;) Team leaders and staff (E) religious leader (M: E and N (x2)) and chief (M:E)
Main themes: FP & God, FP in marriage, male sterilisation
During a bible study, the story of Abraham & Sara is read. Sara could not get a baby until she was about 90 years old. One of the group members (called X) tells that nothing is impossible for God. God will give you a child when the time is right. Another woman (called Y) reacts and says "I have 7 children, and I am 34 years old, I do not want more children. Therefore I asked my husband to

sterilise himself. I don't think God needs to give me so many children, since I do not have the money to feed them." The first woman tells that if she would do that, she'll be acting against Gods will.

- *In this story, there are two women, with whom do you agree? Why?*
- *If you would be the bible study leader, what would you do/say?*
- *Of the woman who would like her husband to be sterilised, what do you think her husband thinks?*
- *What would you advise them?*

Vignette used for SSI staff (C:N) and FGD staff (M:E)
Main themes: FP in marriage, counselling, choice of options, Secret use of FP
X is a mother of two children. Her husband, Y, has a job in the city and is only home during weekends. X has a business and it is busy for her to take care of the children and her growing business. In order to develop her business further, X wants to prevent a third pregnancy. Y however, does not want her to use contraceptives. It is hard for the couple to speak about family planning, since they do not have much time together.
One day X goes to the clinic and asks for family planning options. The worker, Z, shows her the options. He also asks X how her husband thinks about using contraceptives. X tells that her husband does not want her to use contraceptives. Z tells X that it is necessary that a couples make family planning decisions jointly. X tells that she wants to talk about it, but that it is hard since her husband is often living in the city. Z asks her to discuss it with Y first, then she can come and get contraceptives.
A few weeks later, X comes back. She was not able to discuss family planning with her husband. She wants to be sterilized in order to develop her business. Z tells that sterilization without her husband knowing it is too drastic. Z offers her one time Depo, as a temporary solution. The coming three months she has to discuss family planning with her husband in order to make the right contraceptive decision for the long run.

- *Is it common that couples have difficulties in discussing FP?*
- *What do you think about the first reaction of Z, what about the second reaction? Would you react in the same way?*
- *What would X do if Z did not give her the Depo the second time?*

Vignette for unmarried men (C:N, K; E:A,K,J; M:E and N) religious leader (E:K)
Main themes: talk about FP parents-children
X is a man (pastor) of 40 years old. He has a son of 15 years old, named Y. One day he sees that his son is becoming an adult. X remembers how he made a girl pregnant when he was 16 years old. He decides to speak with Y about women and sexuality. He tells that he was quite attracted to a girl in his class and that they slept together. When he heard she was pregnant, he did not want to have any contact with her. He wanted to go to university, not to start a family. While the girl was pregnant, she moved to family on the countryside, he never saw her again. Now he often wonders how she and his child are doing, if they are still alive. He still feels ashamed about the event. He advises his son not to sleep with women until he is getting married and starting a family. Y is impressed by the story of his father.

- *Would you like to have such an open dad?*
- *Is the pregnancy the responsibility of the girl or also of X?*
- *Did you ever speak with your father about sexuality? How do you experience that?*

Vignette used for married women (E:A,K,J; M: E, N; C:N)

Main themes: Secret use of FP, couple and FP

One day X decides to start using the pill. She is married four years ago and has a son and a daughter. The pregnancies were quite heavy, so she does not want to be pregnant again. She buys the pill in the pharmacy. When she is sleeping with her husband, she is not stressed anymore about the probability of getting pregnant. After a year her husband asks her why she is not getting pregnant again. He blames her and even beats her until she shows him the pills at the secret place on the cupboard. He tells her to leave.

- *What do you think of the reaction of the man?*
- *Do you recognise a situation like that?*
- *Is it common to talk about FP within the marriage?*

Vignette used for married women (C:N,U,K)

Themes: FP in marriage, children come from God

When X is pregnant, one of the women who work on the market where she often buys her vegetables is also pregnant. They share their stories and experiences, and get a baby in the same week. Both of the women are healthy, and already have some other children. One year later, the woman who works at the market expects another child. X asks the woman at the market if she is not worried that she will not be able to take care of her children if she will get too many. X tells that she rather waits so that her body can have rest and she will be able to give her children good education. The woman at the market tells "God gave me this pregnancy, and that I am not the one who can decide that this individual should not be born. And if God will give me this baby, he will also give me the means to take care of my children".

- *What do you think will X respond to the woman at the market?*
- *With which woman do you agree? Why?*
- *How do you believe that planning your own family and Gods planning relate to one another?*

Role-plays for FGD staff

- A nurse visits houses to explain about contraceptives to young mothers (E:A)
- A husband of a bleeding wife enters stressed and angry the counselling room, since his wife is very sick from the implant. The nurse has to make him relax and advise him what to do.(E:K)
- A girl of 16 years old accidentally had sex yesterday and now she comes to the clinic to get advice for now and for the future. (E:K)
- Three girls enter the counselling room. One of them is crying because she has been raped. (E:J)
- A couple decides to have sex and to go to the nurse first, to ask for advice concerning pregnancy prevention. (E:J)
- A Health Extension Worker visits a house and wants to advise a girl that lives there, because the HEW knows she recently got a boyfriend. The father of the girl, however, does not want his daughter to be informed about STIs and contraceptives, since he expects that his daughter will abstain from sexual intercourse until she is married. . (E:J)

Annex 3 - FGD with women with a disability

On a Wednesday afternoon my counterpart and I meet with four women with a walking disability. They have come to the village as they wanted to share their stories with us. One woman is not married, has a son aged 14 and got sterilised a while ago. The second woman is married, and has 6 children after 4 other children died before the age of 5. The third woman has one child and similar to the first lady she got sterilised. The fourth woman entered the conversation on a later moment. All three women live about 7 kilometres from Nkhoma hospital and are paralysed.

The women earn a living by receiving help from other people in the community, by growing soya and ground nuts and by making clothes. Someone donated two sewing machines so the women are able to make bags and clothes that are sold on the market. The bags are however sold for only 50 Kwacha (about 10 euro cents) and the women make hardly any profit. They are in need for someone to teach them sewing skills and to help them sell their products.

In this area there is a group for people with a disability which is attended by seven people from both sexes. They meet daily for sewing clothes and they work on income generation together as they are discriminated from working at farms. Farmers do not want to hire them as they think that lame people are not able to do the work well. For this reason the group came together to see what they can do together.

The women face many challenges. Not only are they discriminated for work, they also do not receive subsidized coupons for fertilizer from the government and they do not get a function within the community groups. There is a lot of discrimination according to them.

They never heard of the Uchembere network. According to them this can be explained because they often stay at home and this may be why they are not invited or recognized. In addition, because of their disability two of them got sterilized and so they are not part of the target population.

One of the women said that on her own she would have liked to have more children. But for maternal/prenatal care people have to bring her to the clinic and they don't want to this. Many people instead discourage them to get more children and tell them that it is better to get sterilised. Two women were advised by their mothers to get sterilised as they got a lot of miscarriages already or would give birth along the road when going to the hospital.

The only place where they can access FP methods is in Nkhoma hospital. There are no distributors here in this area. They however cannot walk to Nkhoma and need to find a bicycle (taxi) to get there. Transport is really the biggest problem and it would be helpful to have distributors.