Secure Livelihoods Research Consortium

Everyday politics and practices of family planning in eastern DRC, the case of South Kivu

Key messages:

- Maternal death, mortality of children under five and teenage pregnancy are higher in South Kivu than the rest of the DRC due to continuous conflicts by armed groups in the rural areas and a prolonged transition to recovery in Bukavu city.
- A comprehensive family planning (FP) program is needed, especially in remote areas where media, television and mobile communication is absent.
- A gender approach to FP, aimed at involving more women and men in policy-making, programme-implementation and service delivery would help to create the grounds for behaviourial change towards the acceptance of FP.

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Family, Bukavu City. Family Planning Program, BDOM, Séraphine Lugwarha Nzigire, 2017. *

Research objective

This research project observed the implementation of the Provincial Multi-sector Strategy for Family Planning (PMSSFP) 2014-2020, during the period July 2017 – August 2018 in the Province of South Kivu, eastern DRC, Bukavu and the territories of Walungu and Kabare South and North. Due to time limitations this research did not focus on pharmacies as an additional sector that contributes to contraception delivery, instead it concentrated on institutions that formally collaborated in terms of service delivery. The project had two main aims:

- To bring to light the PMSSFP's main implementation challenges from the perspective of governmental, religious medical institutions and local international non-governmental organisations (INGOs);
- To analyse the effectiveness of the FP programme from the perspective of men, women and youth as service receivers.

* The father in the photo is 35 years old, the mother 28, and they have 12 years of marriage. The family has six children between the ages of one and nine. There is approximately one years' age difference between each child. The mother is currently seven months pregnant. She has had one previous abortion.

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Introduction

The history of family planning (FP) in DRC has witnessed a shift from pro-natality during the Belgian regime to desired natality during Mobutu reign, and in the last decade to responsible natality under the Kabila regime (Romaniuk, 2011; Chirhamolekwa and Miatudila, 2014). The country grew from 12 million inhabitants in 1950 (Romaniuk, 2011) to 79 million in 2015 (see Table 1 for demographic characteristics of DRC). South Kivu in eastern DRC is one of the provinces with the highest rate of fertility with 7.7 children per woman (DHS, 2013-2014). War years marked a higher maternal mortality of 1,178 per 100,000 births in the eastern DRC as compared to 881 per 100,000 in the non-conflict-affected area of West DRC (Lancet, 2006 quoted by Patel et.al., 2016). A demographic characteristic of South Kivu is the large proportion of people under 18 years (3,679,641), making up 56% of the provincial population (South Kivu Population Office), as compared to 46% at the national level (DHS 2013-2014). The eastern part of the countrycontinues to struggle with chronic inner-community conflict over land, water, shelter and natural resources.

The National Multi-sector Strategy of Family Planning (NMSSFP) 2014 – 2020 in the DRC is an integral part of the National Strategy on Sexual and Reproductive Health (NSSRH, 2008) and is aligned with the National Health Development Plan (PNSD) 2011 – 2015. The strategy states that the Congolese government, in matters of family planning, *'favours the choice of responsible parenting and planned births'*.

The two main objectives of the (NMSSFP) 2014 – 2020 are to increase modern contraceptive prevalence from 6.5% in 2013 to 19% by 2020 and to ensure access and modern contraception to 2.1 million additional women by 2020.

Research questions

- Can FP be implemented in fragile settings undergoing socio-economic recovery?
- What are the main challenges faced by governmental and non-governmental institutions which implement the provincial strategy for FP?
- How do the FP services respond (or not) to the needs of youth, men and women in South Kivu?
- Do household poverty, education, cultural and religious beliefs influence the voluntary decision-making for a FP for couples in South-Kivian families?

Methodology

First-hand data was gathered through qualitative research methods: meetings, interviews, and observation with policy makers and service providers from the government, churches and international agencies in the province of South Kivu, in the city of Bukavu, respectively communes of Kadutu, Ibanda and Bagira, and territories of Walungu and Kabare South during July – October 2017, and May – August 2018.

Credit: The RH control bed, and the family planning separate room for consultation between the nurse and the woman or the couple Panzi-Ibanda health zone. Arla Gruda, 2018.

Furthermore, there were conducted face to face interviews with 40 men, women and youth, six focus group discussions with men, women and youth and 5 focus group discussions with health care employees in health centres of Kadutu, Bagira, Walungu, Kabare South and Panzi Protestant Private hospital, as well as interviews

Further data for this study was collected using observation and note-taking in a round-table organised by the Diocesan Office for Medical Services (BDOM) in cooperation with the Provincial Ministry of Health on 6 September 2017, and in the monthly meeting on FP Task Force Committee on Logistical Coordination organized by PDSRH on 15 September 2017.

The governing of family planning in South Kivu

The governance of FP is organised by three levels: At the highest level the Family Planning programme is administered through the National Programme of Reproductive Health at the Ministry of Health. This level is responsible for the development of policies, standards and guidelines. In South Kivu the PMSSFP is integrated in the Provincial Ministry of Health, the Provincial Division of Sexual and Reproductive Health (PDSRH). This intermediate level 'supports the health zones, orientates and coordinates the health action. It is also responsible for the dissemination of centrally developed guidelines and standards' (Interview with Dr. Socrates Çuma, assistant technique of PDSRH). The third level is 'the operation unit for implementing primary health care. It is made of a general referral hospital and health centres, all coordinated by the executive team of the health zones'. (Interview with Dr. Socrates Çuma, assistant technique of PDSRH.)

Each health zone has one Commité de Développement de l'aire de Santé (CODESA, Community Health Committees). CODESA has 6 members, including a main nurse and president of community liaison. (Interview with Dr. Immaculee Mulamba Amisi, the health responsible person at CORDAID for Jeune3 project.)

The NMSSFP (2014-2020) sees Local Religious Institutions (LRIs), INGOs and local civil-society organizations as their partners in the strategy implementation. In the province of South Kivu the role of the two main (LRIs), Bureau Diocesan des Oeuvres Medical (BDOM, Diocesan Office of Medical Services) and Bureau Protestant des Oeuvres Medical (BYCOP, Protestant Office of Medical Services) is reached through trainings they deliver respectively in 12 and six health zones. BYCOP, apart from trainings, provides 10 types of contraception delivery in six health zones. INGOs provide training expertise, logistical support as well as deliver contraception in health zones. The International + Solutions (I+Solutions) assists the PDSRH to identify the chain of contraception supply (Interview with Dr. Michel Yalasa, country representative at I+Solutions for the DRC). South Kivu has 34 health zones, but none of the INGOs or RLIs operate in all of them. Each INGO operates in 4-8 health zones where SRH and FP are integrated into their health-care support for two, three or five years. (Interviews with representatives from German Cooperation, Swiss Cooperation, UNFPA, UNICEF, CORDAID, Women for Women International, IOM, MSF, IRC.)

The role of government in communicating FP services

South Kivu has full coverage of the FP services in all of its 34 health zones. Whilst it is a positive model for other provinces the demand for FP services remains a challenge for the PDSRH to implement the PMSSFP.

Creating demand to use services requires communication strategies that encourages the acceptance of FP as a strategy that improves the health of the mother and child, the economy and education of household members. Governmental, INGOs and religious organisations have created various channels to communicate these messages.

At the local level health care employees in the health centres provide FP sessions with couples. These sessions are not supervised and are mentored by FP communication experts. While training is organized by CODESA, with nurses and pharmacists, after the training, the health-care employees are left to follow written guidelines. The research interviews with teenagers and youth, and with men and women of reproductive age not in union, indicate there is a strong judgemental attitude by health care employees towards them when approaching health centres for contraception information. Contraceptives, which are donations of INGOs in health centres, and are supposed to be provided for free, are sold to the population by the pharmacist and health-care employees below market rate. Our findings demonstrate that health care employees often are unmotivated and therefore take an unprofessional attitude towards service receivers. Focus group discussions in Walungu, Kabare South and Bagira health zones indicate that many nurses are not regularly paid and have secondary sources of income to supplement their salaries.

In order to reach families in remote areas, the provincial government has created Community Liaison Officers (CLOS). This research finds that this initiative has not been very effective. Officers are not well-trained, there is no financial motivation for these community members, and there is no logistical material to support their walk through mountains (e.g. boots, backpacks and rain coats).

Creating demand to use services requires communication strategies that encourages the acceptance of FP

In the NMSSFP activity plan for 2014 the government aimed to include youth and unmarried men and women at the provincial level strategies. The research found that media campaigns do not transmit this message, nor are the health care employees open to reaching these population groups – especially in rural areas.

The role of INGOs and religious institutions in creating an enabling environment for FP

The communications strategy used by international organisations for FP only happens annually – at most bi-annually – for one to three days, with community campaigns delivered through megaphones and leaflets. For example in Kabare territory during 2014, INGOs, such as UNFPA, Swiss Cooperation, and International Rescue Committee (IRC) came together with the provincial Ministry of Health and journalists to undertake a three day campaign, which successfully raised the demand for contraception from 9 to 13%. However the demand created was not able to be met. (Interviews with Eustache Ndokabilya Dunia, Health Program Responsible for Swiss Cooperation, and Ishukwe Wasolu, Supervisor for Reproduction Health in Kalehe, IRC.)

The Dutch Catholic Organisation on Relief and Development Aid (CORDAID) through their JeuneS3 (Santé, Sexualité, Securité, 'Health, Sexuality, Security) project have created new spaces to train youth on SRH, leadership and personal values. Other INGOs, such as Swiss TPH, part of the JeuneS3 consortium, is training youth on the Comprehensive Sexual and Reproductive Health (CSRH) module prepared by UNICEF and UNESCO guidelines. (Interviews with Seydou Ndiay, project coordinator JeuneS3, CORDAID, and Ernest Mendy, coordinator JeuneS3, Swiss TPH.)

The only institutions with daily and weekly communication power are the catholic and protestant parishes. They can deliver communication on family planning during the Sunday prayers or through the Church educational department and women's health groups (interviews with two family educational leaders in the Catholic Parish of Nguba at Ibanda commune, with the Protestant Parish leader of Ibanda, and the female director of the Association of Protestant Women.)

New curriculum sessions on SRH and FP have been developed by the Directorate of Family Life and Population Education at School, the Ministry of Primary Secondary and Vocational Education which in 2013 upgraded the Catholic Curricula 'Education for Life' (1976), with the new curricula 'Programme National D'Education a La Vie Familiale' (the National Program of the Family Life Education. The update was provided with the technical and financial support by UNICEF, UNESCO and JeuneS3 of the Ministry of Foreign Affairs of the Netherlands. The New Comprehensive Curricula on SRH, unlike Education for Life, inserts sessions on sexual violence, early marriages and teenage pregnancies, and speaks of population reduction rather than birth-spacing. (Interview with Ernest Mendy, Swiss TPH.)

Given the prominence of religious groups, one important finding of the research is that, while not being in favour of new contraceptive methods, the Catholic Church is aware of the need for FP. The Catholic Church Bureau Diocesan of Medical Services (BDOM) argues that religious community leaders should, and can, embrace their role as communicators of Family Planning. (Interviews with the male Educational Coordinator at Nguba Catholic Parish, and Sister Maria Mason, president of the BDOM.)

Credit: Focus group discussion with community liaison officers and nurses of Kadutu health zone. Arla Gruda, October 2017.

Since SRH and birth spacing are a taboo topic for parents of adolescent children in South Kivu, schools and churches play an important role in FP. The research noted that 'Education for Life' by Educational Institution of the Catholic Church and biology sessions on Sexual and Reproductive Health provide information to students which they cannot be offered from parents or family members. (Focus group with four male and four female students, Ibanda High School.)

Effectiveness of the family planning programme from the perspective of INGOS, men, women and youth

A major finding of the research is that FP programmes need to improve FP information to non-married youth. The youth program Jeune3 coordinated by CORDAID in consortium with World Youth Association, Swiss TPH, and I+Solutions is creating some spaces where young people are able to ask questions, to inform themselves about SRH and to be provided with condoms. (Interviews with Seydou Ndiay and Ernest Mendy.)

CORDAID has initiated a programme to train religious leaders and parents on youth education. A pilot project begun in February 2018 to train parents in collaboration with the schools in Miti-Moresa using a pamphlet ('Where are babies coming from?') explaining how parents can respond to 32 common questions asked by children. Another facilitation guide for religious leaders was drafted by CORDAID, and is being piloted in rural areas of South Kivu. The trainers reported that some church leaders found it important to break the silence and inform youth on early pregnancy. (Interview with Dr. Immaculee Mulamba Amisi, the health responsible person at CORDAID for Jeune3 project.)

The research found that health centres do not always engage with men and there continues to be a strong perception that contraception is for women. Men feel that they should be invited by health centres for informative sessions.

The most favoured contraception method used by women between 25 – 35 years old is the depo provera injection and arm implant. Contraceptive pills are not a favorite type of contraception due to their adverse side effects and the requirement to take them daily. (Interviews with men and women in unions, aged 20 – 34 and 35 – 49, in the health zones of Kadutu, Ibanda Bagira.)

Factors impacting FP use

The research found that family planning decision-making between men and women differs by age, education, locality (rural versus urban), religious and cultural beliefs, and by the number of children couples already have. Approximately 62.5% of first-born children are non-planned and in 30% of cases occur out of wed-lock, during teenage years (16 – 19 years). Six young men and two young women in Ibanda and Bagira communes reported being forced by their parents to marry their sexual partner following the discovery of an unwanted

pregnancy. Nevertheless, first unwanted pregnancies do not impact the decision-making of men and women to start family planning earlier (interviews with 40 men and women in Ibanda and Bagira commune in South Kivu.)

A major factor in the uptake of FP is whether parents and communities see FP as helping them cope with poverty – with more interest and acceptance in urban than rural areas. The research found that there was not necessarily a direct correlation between household poverty and increase in the demand for family planning in rural areas because children are cared for in communities and extended families. (Interviews with men and women in unions, 20 – 34 and 35 – 49 years old, in the health zones of Kadutu, Ibanda, Kabare and Walungu.)

The absence of trained and knowledgeable women in positions of policy-making, policy-execution and service delivery in health centres is an obstacle in creating communication strategies that reach women of diverse ages, locations, education, employment backgrounds and religious beliefs. (Researcher observation during meetings, interviews and focus groups in governmental and non-governmental institutions.)

Men between 22 – 30 years old were more open to discussing FP with their wives if they had already had an unwanted pregnancy. (Focus group with eight men of reproductive age 28 – 52 years old, health centre Panzi area, Ibanda Commune, Bukavu.)

The research found that women of reproduction ages 35 – 42 tend to be more conservative and will only consider contraception after having six children. There is a strong cultural perception that women with six children are considered powerful members of the community. (Interviews with women of reproductive age 35 – 49 years old in the health zones of Ibanda, Bagira, Kadutu and Walungu.)

The research found little awareness of the possibility of vasectomy with men viewing contraception as their wives responsibilty. Although condoms are widely known about, they are not used by married couples, who rely on other contraception methods. (Interviews with males, 20 – 52 years old in health zones of Ibanda, Bagira, Kadutu, Kabare.)

The research found that the economic conditions under which health care staff operated created room for clientelism over contraception. The clientelism led to the perception among the community that contraception is not provided for free at the health areas and prevented women and men with few financial resources to approach health areas for contraceptive advice. (Focus group discussion with eight females, 20 – 45 years old at Kadutu health zone.)

The research also found that the privacy of informed choices by men and women was violated in the cases when CLOs and nurses transferred the services into the plantation field, and performed arm implants in exchange for a bra or a sack of flower. (Interviews with female trainer of Catholic Church and INGOs on SRH and FP.)

Recommendations

1. South Kivu needs to create a FP programme that is sensitive to the family typology, age, location, socio-economic status, religious belief of male and female family members, and is sensitive to diversity among people's experiences and ways of living.
2. The unmet need for contraception is an international community and governmental strategy which needs to be translated into communication that can lead to behavioural change.
3. The absence of trained and knowledgeable women in positions of policy-making, policy-execution and service delivery in health centres is an obstacle in creating communication strategies that reach women of diverse ages, locations, education, employment backgrounds and religious beliefs.
4. Local religious leaders have more power to be opinion leaders than the Provincial Government and INGO community when communicating FP messages to the local population. Training religious leaders of various parishes in remote areas will help FP awareness and behavioural change.
5. Since 56% of the population in South Kivu are under 18, the inclusion of parents in training sessions on comprehensive SRH could enrich both parents and youth on understanding gender systems and norms in their communities and can help both boys and girls to live a life without sexual violence, early pregnancies or sexually transmitted diseases.

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