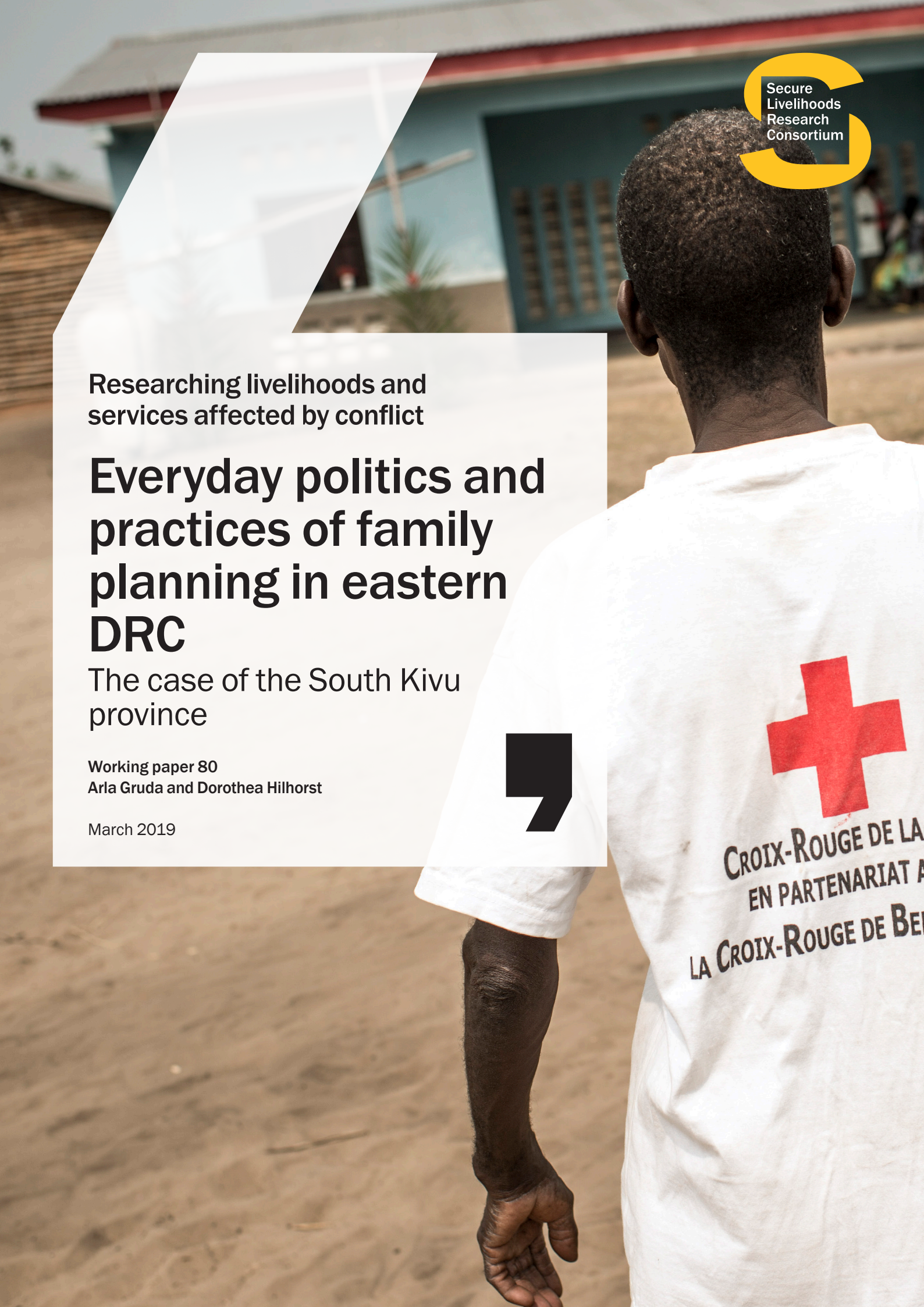

Researching livelihoods and services affected by conflict

Everyday politics and practices of family planning in eastern DRC

The case of the South Kivu province

Working paper 80
Arla Gruda and Dorothea Hilhorst

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SLRC publications present information, analysis and key policy recommendations on issues relating to livelihoods, basic services and social protection in conflict affected situations. This and other SLRC publications are available from **www.securelivelihoods.org**. Funded by UK aid from the UK Government, Irish Aid and the EC.

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Cover photo: Health professional walking toward health center in small village near Mosango. © H6 Partners.

About us

The Secure Livelihoods Research Consortium (SLRC) is a global research programme exploring basic services, and social protection in fragile and conflict-affected situations. Funded by UK Aid from the UK Government (DFID), with complementary funding from Irish Aid and the European Commission (EC), SLRC was established in 2011 with the aim of strengthening the evidence base and informing policy and practice around livelihoods and services in conflict.

The Overseas Development Institute (ODI) is the lead organisation. SLRC partners include: Centre for Poverty Analysis (CEPA), Feinstein International Center (FIC, Tufts University), Focus1000, Afghanistan Research and Evaluation Unit (AREU), Sustainable Development Policy Institute (SDPI), Wageningen University (WUR), Nepal Centre for Contemporary Research (NCCR), Busara Center for Behavioral Economics, Nepal Institute for Social and Environmental Research (NISER), Narrate, Social Scientists' Association of Sri Lanka (SSA), Food and Agriculture Organization (FAO), Women and Rural Development Network (WORUDET), Claremont Graduate University (CGU), Institute of Development Policy (IOB, University of Antwerp) and the International Institute of Social Studies (ISS, Erasmus University of Rotterdam).

SLRC's research can be separated into two phases. Our first phase of research (2011 - 2017) was based on three research questions, developed over the course of an intensive one-year inception phase:

- State legitimacy: experiences, perceptions and expectations of the state and local governance in conflict-affected situations
- State capacity: building effective states that deliver services and social protection in conflict-affected situations
- Livelihood trajectories and economic activity under conflict

Guided by our original research questions on state legitimacy, state capacity, and livelihoods, the second phase of SLRC research (2017-2019) delves into questions that still remain, organised into three themes of research. In addition to these themes, SLRC II also has a programme component exploring power and everyday politics in the Democratic Republic of Congo (DRC). For more information on our work, visit: www.securelivelihoods.org/what-we-do

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Acronyms and glossary

BDOM	Bureau Diocesan des Oeuvres Medical ([Catholic] Diocesan Office for Medical Services)
BYCOP	Bureau Protestant des Oeuvres Medical (Protestant Office for Medical Services)
CARE	Cooperative for Assistance and Relief Everywhere
CLO	Community liaison officer
CODESA	Committee Development de Sante (Health Development Committee)
CSO	Civil-Society Organisation
DFID	(UK Government) Department for International Development
DHS	Demographic Health Survey
DRC	Democratic Republic of the Congo
FP	Family planning
FPP	Family planning programmes
FPS	Family planning services
HZ	Health Zone
INGO	International non-governmental organisation
IUD	Intra-Uterine Device
LRI	Local religious institution
LWO	Local women's organisation
NGO	Non-governmental organisation
NMSSFP	National Multi-Sectoral Strategy on Family Planning
ODA	Official development assistance
PDSRH	Provincial Division on Sexual and Reproductive Health Rights (SRHR)
RMI	Religious medical institution
SDGs	Sustainable Development Goals
SLRC	Secure Livelihoods Research Consortium
SOFEDI	Solidarité des Femmes pour le Développement Integral (Women Solidarity for Integral Development)
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health rights
Swiss TPH	Swiss Tropical and Public Health Institute
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children's Emergency Fund
USAID	United States Agency for International Development

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Executive summary

This paper provides a case study of the politics and practices of family planning (FP) in the province of South Kivu in the Democratic Republic of the Congo (DRC). It is underpinned by research exploring the use (and non-use) of family planning services (FPSs) by women and men of reproductive age and young people, via 40 face-to-face one-to-one interviews and six focus-group discussions, along with five focus-group discussions with healthcare employees in various health centres and Panzi Hospital in Bukavu city. Thirty-one qualitative face-to-face interviews and meetings were conducted with policymakers and service providers from the government, churches and international agencies.

Furthermore, the research explores education services for young people on sexual and reproductive health (SRH) and the actions that government and non-governmental organisations (NGOs) have taken to increase the demand for FPSs.

Findings

This study has found that family life is changing rapidly in eastern DRC. Monogamy has become a norm in marital relationships and polygamy is rarely found in men over 50 years old. Families of our research participants are smaller in size than their parents' generation.

The study has also discovered a high number of first unwanted pregnancies happening out of wedlock, reflecting a lack of contraceptive use in non-marital sexual relations. The major obstacle to FP is thus related to societal norms rather than state fragility.

We identified two distinct groups of people who could particularly benefit from improved FP services:

- Couples with children – Couples often consider FP after their fifth or sixth child. We found a huge potential demand for what may be called *pre-family planning*: the planning of pregnancies before marriage.
- Unmarried couples – We found that 62.5% of first-time pregnancies of participants were unplanned and undesired. In most of these instances, the pregnancy forced young couples to marry. In addition, 40% of pregnancies after the first child were not planned.

Despite positive efforts by the provincial government, we found a number of problems with the governance of FP, including issues with payment of health providers and community liaison officers (CLOs). Together, these have resulted in a mechanical FP system; government health facilities are geared towards maximising the adoption of FP, which is sometimes unduly enforced. Churches tend to better understand the importance of couples' free choice more than CLOs and some healthcare employees, but continue to convey a bias towards natural methods.

Conclusions and recommendations

- Local government and religious medical institutions should develop a strategy to inform the Bukavian citizens on the role of international non-governmental organisations (INGOs) and donors related to FP services.
- Donors and INGOs should feel supported in the recognition that there is need for them to be more present in the health centres and community infrastructure.
- In South Kivu, eastern DRC FP programmes need to create a programme that is sensitive to the family typology, age, location, socio-economic status and religious belief of family members, as well as the diversity of people's experiences and ways of living.
- When communicating FP messages to the local population, local religious leaders have more power to be opinion leaders than the Provincial Government and INGO community. Training leaders of various parishes in remote areas will encourage wider FP awareness and behavioural change.
- Since 56% of the population in South-Kivu are under 18, the inclusion of parents in training sessions on how to communicate SRH knowledge to their

adolescent children will enable youth to be more open about communicating their fears and asking questions about their first sexual encounters, thereby helping them to avoid teenage pregnancy.

- The introduction of a comprehensive SRH curricula can enrich young people's understanding of the gender systems and norms in their communities and can help them live a youth without sexual violence, early pregnancies or sexually transmitted diseases.

1 Introduction

Family planning in fragile settings is riddled with complex challenges. For a long time it was a neglected aspect of service delivery in conflict-affected areas, as it was not considered an immediate humanitarian need. In conflict situations, humanitarian aid tended to focus on those needs that were directly triggered by the conflict, whereas maintaining normality through education and health services in areas not directly affected by the conflict was relatively neglected (Sturge et al., 2017).

Despite international commitments to increase support for SRH in conflict-affected situations, official development assistance (ODA) disbursement patterns regarding SRH between 2002 and 2011 were 50% higher for non-conflict countries than for conflict-affected ones (Patel et al., 2016). FP in conflict-affected areas and fragile settings is now receiving more international and governmental attention. In 2010, the United Nations Population Fund (UNFPA), International Planned Parenthood Federation (IPPF) and the FP2020 consortium introduced specific agendas to cover SRH and FP for women in crisis-affected settings (Curry et al., 2015). In 18 conflicted countries (including DRC), ODA disbursement increased 258% between 2002 and 2011. However, this increase was mostly due to HIV/AIDS programmes (Patel et al., 2016). Overseas Development Aid for the DRC was $44.5 million in 2002, and by 2011 had reached $172.2 million – of which 58.2% was for reproductive health (Patel et al., 2016).

Fragile settings are beset by a number of interlocking 'wicked problems',[1] and they score low on all the Sustainable Development Goals (SDGs). Conflict is usually accompanied by a major disturbance of economic life, along with high poverty levels and sharply reduced levels of service delivery – hampered by weak governance. These are also often the countries with the highest birth rates – although the connection between increased or decreased fertility rates and insecurity during war years is difficult to prove (McGinn, 2000; Black et al., 2014).

This paper provides a case study of the politics and practices of FP programmes in the fragile setting of the DRC, especially focusing on the province of South Kivu. The DRC is found on every list of fragile settings. Decades of war and recurring conflicts have heavily affected the

1 'Wicked problems' is a terminology widely used in the last few decades, particularly for social public policies, to describe social or cultural problems that seem difficult to resolve due to differences in opinions and economic burdens. SDGs are also considered 'wicked problems' – for example, there is nonetheless the unresolved matter of global hunger or global poverty. Also see Head (2008) and Batie (2008).

country, which ranks 176th out of 189 on the Human Development Index (2018 statistics). Research on FP in the DRC has hitherto mainly consisted of four types. First, there has been research into the need for FP in refugee camps and other areas directly affected by the conflict where FP was part of humanitarian-service delivery (Curry et al., 2015; Kisindja et al., 2017; Casey and Tshipamba, 2017; Ackerson and Zielinski, 2017). Second, there have been a number of studies that have analysed the political environment, that contributed to the drafting of the National Multi-sectoral Strategy on Family Planning (NMSSFP) for 2014–2020 in the DRC (Mukaba et al., 2015), and quantitatively monitored the geographical coverage of the FP services in Kinshasa and 11 other provinces of the DRC (Mugisho, 2016; Mukaba et al., 2015; Kayembe et al., 2015; Hernandez, et al., 2016; Mpunga, et al., 2017). Third, there has been research on healthcare delivery approaches, analysing the experience of contraception that people in different provinces have had (Chabikuli and Lukanu, 2007; Ntambue Ml. et. al., 2012; Chirwa, et al., 2014). A fourth research trend takes a sociological approach to fertility and FP (Shapiro, 1996, 2015; Dhakal, Eun and Ho, 2016; Muanda, et al., 2016).

This paper aims to contribute to the knowledge base on FP in the DRC by providing a qualitative case study on the province of South Kivu, conducted between July 2017 and August 2018. Since 1996, Kivu (which is in eastern DRC) has experienced chronic periods of war and armed conflict. As a result, FP implementation in the southern part of the province has a component of fragility. This gives the region a unique experience of FP compared with other provinces in western DRC that have not experienced conflict. This makes eastern DRC an interesting site of study. Furthermore, since the drafting of the NMSSFP for 2014-2020, South Kivu has had the highest coverage of FP nationally, encompassing 32 of 34 health zones (HZs). It can be considered a model province for FP in the DRC. Therefore, choosing to analyse South Kivu provides an example for other provinces and governmental and NGOs in those regions to follow in providing FP services. Our research fills the gap in the literature on how a provincial FP strategy can be implemented through the joint efforts of provincial government, local healthcare employees, CLOs, local Catholic and Protestant medical institutions, INGOs and local women's organisations (LWOs).

Our paper focuses on the implementation of the Provincial Multisector Strategy for Family Planning (PMSSFP) 2014–2020. It is based on three data-sets: in-depth interviews and focus groups with different types of service providers in the Ibanda, Bagira and Kadutu communes of Bukavu city, and Walungu and Kabare South territories in South Kivu; a descriptive analysis of education on Comprehensive Sexual and Reproductive Health (CSRH) for young people and communication approaches to FP; and interviews and focus groups with adults and young people in marital or other sexual relationships in Bukavu city. It answers research questions on the challenges of FP strategy implementation from the perspective of governmental and non-governmental service providers and service users. It poses the following questions:

- How do FP programmes impact on the lives of the women and men who wish to access FP or are already using FP services in eastern Congolese households in South Kivu?
- How do FP programmes interact with the societal, cultural, religious and economic factors influencing FP decision-making in South Kivian households?
- What are the experiences of young people and adults with SRH education in their homes, classrooms and churches?

The research takes a gender perspective, including the voices of both women and men as policymakers, service providers and service users. Since few services are as gendered as family planning, an additional layer of our analysis concerns how gender norms and non-mainstreaming gender approaches at all levels of policy-making and service provision interfere – or not – with FP.

Service delivery in the DRC is fragmented and can be seen as an arena in which a number of different actors operate – notably the government, churches and international aid organisations. During our research, we observed that women's civil-society organisations (CSOs) working on temporary projects on SRH and FP are few in number and have no notable impact on national policies. While a multiplicity of service providers is more the rule than the exception in most low-income and fragile countries, the DRC largely lacks central regulation, coordination and monitoring of services. Its three main types of service provider do not operate in isolation from each other as there are many overlaps – such as church-led hospitals that are part of the national health system, which is largely funded by international sources. Nonetheless, at the level of implementation there are, to some extent, parallel services, and we will analyse how these different providers approach FP. Due to time limitations this research did not focus on private pharmacies, but these also play a role in FP, and a number of the women

interviewed mentioned buying contraceptive methods in such outlets.

This paper starts with a review of pertinent literature on FP in fragile settings and service delivery in the DRC. It also considers the history and characteristics of FP in the country, and its gender relations and policies. Following an account of the methodology, the main characteristics of the research population are presented, including trends in the demand for FP. In subsequent sections, the findings are presented around three main questions:

- challenges related to service provision
- FP decision-making in the family
- people's perspectives on FP programmes.

2 Literature review

2.1 Family planning in fragile settings

Voluntary family planning programmes have been part of development programming since the 1970s, and are generally seen as contributing to socio-economic agendas, women's rights and human rights per se. The effects of family planning programmes (FPPs) – in addition to reducing the number of children – include reductions in maternal mortality, child mortality under five years and improving the health of mothers and their children (Bongaarts, 2014; Bradley et al., 2012; Longwe and Smits, 2012). FPPs have enabled women to have higher rates of education and to participate in the labour market, and have increased the educational attainment for children between eight and 11 years (Senanayake, 1999). The effects of FPPs on broader economic development are more difficult to establish, and may have negative aspects as well as positive ones (Bongaarts, 2014; Canning and Schultz, 2012).

The voluntary aspect of FP for those taking up the services means that individual informed choice is a key aspect of programming. Access to contraception for all adults and young people, whether in union or not, is considered part of the universal right for accessible, accountable, affordable SRH (International Covenant on Economic, Social and Cultural Rights, 1966/1976; International Conference on Population and Development, 1994; Commission on Social Determinants of Health, 2007). However, many countries have developed either pro-natality policies (including a ban on abortion) or anti-natality policies (for example, through forced sterilisation) (Kabeer, 2004; Gruda, 2007). Demands for FP, based on Demographic and Health Surveys (DHSs), pertain to women of reproductive age who:

- desire to have fewer children in the coming 2½ years
- have experienced unwanted pregnancies or
- are carrying a child that was not planned or wanted at that moment in time, and are not using/have not used contraception (Senanayake, 1999; Bradley et al., 2012).

Many challenges remain due to the following DHS attributes:

- different definitions of unmet need over time, as used in DHS surveys
- the number of questions, including whether there is calendar data or not, used consequently in every DHS survey per country
- the way in which insecurity is measured
- the way in which women giving inconsistent answers is dealt with (Senanayake, 1999; Bradley et al., 2012).

VFP as an international development policy for low-income countries reached a peak in the 1970s in Indonesia, India, North Africa and Brazil. By the 1990s, international political attention towards FP in the Global South had reduced for a number of reasons. First, HIV/AIDS became a more pressing issue to deal with – especially in Anglophone Africa. Second, many national governments ceased to commit politically and financially to FPP. Also, in many countries, the influence of religious institutions steered governments away from condoning modern forms of contraception (Kabeer, 2004). In recent years, the attention given to FP among donors has increased, partly inspired by concerns over international migration (Ezeh, Bongaarts and Mberu, 2012).

In fragile settings, attention to FP often focuses on specific conflict-related reproductive-health issues, such as care for people who have been sexually abused (McGinn, 2000; Black et al., 2014). The connections between increased or decreased fertility levels and insecurity during wartime are difficult to prove (McGinn, 2000; Black et al., 2014). Nonetheless, it is obvious that reproduction carries on during times of distress and women continue to have reproductive health needs. Considering the protracted nature of many crises today, attention to FP is important for well-being and gender equality. Yet, there are many challenges to overcome.

One such challenge is that, during conflict and post-conflict recovery, human rights are not a priority for national governments and international actors compared with other concerns such as the basic nutrition and health of conflict-affected populations. Humanitarian international aid has neglected SRH and FP in comparison with other health issues (Ratnayake et al., 2014; Black et al., 2014; Curry et al., 2015; Tunçalp et al., 2015; Patel et al., 2016). The first consolidated call to introduce consideration of reproductive health for women in camps for refugees and those for internally displaced people came from women's groups at the International Conference on Population and Development, in Cairo, Egypt, 5-13 September 1994 (UNHCR 1999; Petchesky, 2000; McGinn, 2000; Black et al., 2014). By 2010, UNFPA, International Planned Parenthood Federation (IPPF) and FP2020 had introduced specific agendas to cover SRH and FP for women in crisis-affected settings (Curry et al., 2015).

There are, in fact, positive examples of FP and reproductive health in conflict-affected areas. For example, the Cooperative for Assistance and Relief Everywhere (CARE International) initiative – Supporting Access to Family Planning and Post-Abortion Care in Emergencies (SAFPAC) – worked in four conflicted-affected settings in sub-Saharan Africa (DRC, Mali, Chad and Djibouti) as well as in Pakistan between 2011 and 2013. This programme demonstrated that FP is feasible in such settings (Curry et al., 2015) and showed that training of health care employees, good management of supply chains, and systematic supervision and community mobilisation are all key to the success of FP in conflicted areas (Curry et al., 2015). A recent literature review on factors that influence the use of contraception by women in crisis-affected Sub-Saharan Africa further showed that respect and culturally sensitive behavior by healthcare employees are key factors, as well as education of communities on contraceptive methods and strategies to access affordable and voluntary family planning services (Ackerson and Zielinski, 2017).

2.2 Service delivery in the DRC

The DRC is the second-largest country in Africa and, despite an abundance of natural resources, one of the economically poorest. In 2015, the national country data reported a population of 79.3 million inhabitants. This can be found on the family planning national website[2], though the rigour of gathering data-sets and methodologies is arguably questionable (Thontwa et al., 2017). However, World Bank estimates in 2016 reached 78.7 million inhabitants. By 2015, 42.5% of the population lived in urban areas and about 46% were younger than 15.

The current state, organisation and practice of service delivery result from developments during and after colonialism and the devastating effects of the First (1966–1967) and Second (1998–2002) Congo Wars. These conflicts formally ended in 2002, but the country – especially its eastern half – has continued to experience many localised armed conflicts (Verweijen and Wakenge, 2015). Belgian colonialism failed to bequeath an administration with the capacity to handle the country's infrastructure after independence (Freedman, 2015; Department for International Development (DFID), 2016). During the long reign of Mobutu Sese Seko (1960–1997), which was characterised by a clientelist style of government that endowed supporters with positions in

2 http://www.familyplanning-drc.net/

public service, there was a system of service delivery that routinely relied on user fees (Titeca and de Herdt, 2011). The salaries of public servants were not covered, and they had to supplement their income by exploiting the populace (Vlassenroot and Romkema, 2007).

The DRC's population has mainly depended on non-state actors for the provision of basic social services; these are especially important in the arena of public health. Churches in particular have shouldered the main responsibility for organising health services, and in recent decades – since 2004, after the war years – this process has been largely subsidised by international donor funding. Bwimana points out that 85% of DRC health expenses are provided by donors – whereby, for example, 'between 2008 to 2012, international aid given to the DRC health sector amounted to 16,550 million USD' (Bwimana, 2017, p. 24). Although service inputs have not been homogeneous across provinces or the HZs within them (Pavignani et. al., 2013; Pearson, 2011), there is nonetheless a sustained presence for the sector in terms of policy, health-system management and service delivery (Bwimana, 2017). Nonetheless, service provision continues to be hampered by huge arrears in the payment of civil servants, locally referred to as the 'payroll issue', and hence the glaring absence of a social contract whereby the population might expect the government to take responsibility for their basic needs.

Historically speaking, human-resource management of civil servants in the DRC was decentralised in 1972. Nine years later, in 1981, the first Statute of the Civil Servant introduced the 'salary supplement' and, in many cases, this was higher than the salary itself (DFID, 2016). Due to the withdrawal of International Monetary Fund (IMF) support for salary disbursement in the civil-service sector, many health centres and hospitals were turned into profit-making enterprises by 1990, in lieu of a payroll (DFID, 2016). The country's third round of civil-service reform occurred under the Kabila regime (2003–2010). This aimed to input an audit-and-pensioning scheme. Despite many international donors giving support to the DRC Government in order for it to implement the reform, the new measures were declared a failure by 2010 (DFID, 2016). The two last efforts by international donors to support wage payments and recruitment on merit, and introduce a digital register for civil-servants employed by the government happened between 2013 and 2016. They took place under the aegis of DFID and, in 2014–2019, under the World Bank, which targeted the ministries of Finance, Budget and Planning.

The health sector in the DRC is organised in a pyramid shape organisation and involves central (national), intermediate (provincial) and operational levels. The latter are referred to as HZs (Bukonda et. al., 2012). Although policy-making is an exclusive function of the Ministry of Health, donors and other development partners inform and support the process through technical and financial assistance. As a result, policy often reflects internationally agreed values and directions that may vastly diverge from the actual practices in the country. The HZ is the operational unit that integrates primary healthcare services and the first-referral level. It covers an average population of 110,000 and consists of a central HZ office, an array of health posts and centres, and a general referral hospital (Carlson et. al., 2005; World Bank, 2005). The province of South Kivu, where this research took place, has 36 HZs. Because of the lack of government financing over the last few decades, HZs and their constituent facilities have operated with considerable autonomy. Many facilities have become, in effect, privatised – relying on patient fees to pay staff and operating costs (Carlson et. al., 2005; Bwimana, 2017).

The health system in the DRC is therefore fragmented and uneven. Due to the different service providers and a significant absence of meta-governance or central coordination, health services constitute a social arena (Hilhorst and Jansen, 2010): a symbolic location in which health services evolve from the interaction (and lack of interaction) of different service providers. The multiplicity of institutions in service delivery creates different forms of governance of programmes and projects, all overlapping with each other (Weijs et al., 2012). A number of donors are seen as traditional partners; this gives added value to these governmental programmes, which aim to strengthen the health system as a whole. However, over the past few decades of continued state weakness and insecurity, it has been common for donors to favour special projects and humanitarian interventions, focusing on specific situations of social vulnerability. The frequent use of varying policies and stand-alone projects has further contributed to a decentralised and fragmented system.

2.3 Family planning in the DRC: history, policy and organisation

In 2015 the birth rate in the DRC was estimated to be 5.9 children per woman, which ranks DRC very highly on global scales of female fertility. In the 1950s, the birth rate in Kinshasa was 7.5 per woman, declining to 5.7 in 1975 and 3.9 in 2007 (Shapiro 1996, 2015). This transition has been attributed to an improvement in the

education levels of women, a postponement of the age of marriage and a delay in starting a family because of economic hardship (Shapiro, 2015). The DHS 2013–2014 survey indicated that the birth rate in Kinshasa was 4.4. South Kivu, where this research took place, had a higher rate of 7.4 by 2007 (Romaniuk, 2011). A high rate in families with incomes of less than $50 per month has been associated with a combination of societal and political factors. Some of the former are connected to a patriarchal society, religious ideology, pro-natality societal norms, a lack of joint parental decision-making over the number of children, intimate partner violence and armed conflict (Romaniuk, 2011; Kidman et al., 2015). Lack of political commitment and budget allocation to FP, and scarcity of modern contraceptive methods are regarded as other political factors playing a role in the high birth rate (Mukaba et al., 2015; Muanda et al., 2016).

Over the last century, the history of FP in the DRC has seen phases of policies shifting between a pro-natality and controlled natality stance. Prior to colonial times, the DRC suffered a drop in the birth rate due to slavery-related mass movements towards other countries and to infectious diseases (Romaniuk, 2011; Chirhamolekwa and Miatudila, 2014). The colonial regime introduced pro-natality policies as a means to secure socio-economic growth for Belgium, through population growth in its African colony (Chirhamolekwa and Miatudila, 2014). By the 1950s, the population of the then Belgian Congo was 12 million (Romaniuk, 2011). Its birth rate was higher in urban areas than today's urban rate. Kinshasa in the 1950s had the highest rate in the country, with eight children per woman compared with four to six in rural areas. Meanwhile, Kinshasa currently has the lowest rate (four children per woman) and rural areas eight to 14 children (Romaniuk, 2011; Chirhamolekwa and Miatudila, 2014). The higher urban birth rate in the 1950s can be explained by anti-abortion legislation and the generous family packages introduced under Belgian rule (Chirhamolekwa and Miatudila, 2014); rural areas at that time were hit by internal migration of the population towards the urban centres. Today, the lower birth rate in Kinshasa is related to women entering higher education and the labour market, and delaying the age of marriage as well as that of having a first child (Shapiro 1996, 2015). The increase of population in the DRC's rural areas is connected to the strong roots of the traditional social system, which valorises reproduction and delayed modernisation (Romaniuk, 2011).

With independence from Belgian rule and the rule of Mobutuo from 1965 until 1997, an FP strategy was fostered via the language of 'desired births' (Chirhamolekwa and Miatudila, 2014). By the late 1980s, Mobutu's strategy was attracting US aid, which then withdrew during the war years between 1996 and 2004 under the two regimes of father and son Kabila (Mukaba et al., 2015). The first decade of the Kabila regime gave no priority to controlling the country's population dynamics. Post-war, by 2010, the DRC had commenced its socio-economic recovery. Here, there was a lobbying drive from the UNFPA, the United States Agency for International Development (USAID) and the United Nations International Children's Emergency Fund (UNICEF) towards the Kabila government. This, along with the continuous exposure of DRC politicians to international regional conferences on FP, succeeded in gaining FP momentum for the DRC in 2012 (Mukaba et al., 2015). As a result of three national conferences on FP and continuous international exposure to neighbouring countries, the Congolese Government drafted the NMSSFP as a derivate of the National Program on Sexual and Reproductive Health (2001).

However, from the beginning of the NMSSFP in the DRC (Mukaba et al., 2015), the policy was under threat because of the unstable political environment, including turmoil surrounding local elections, which risked donor withdrawal, and the ongoing conflicts in the east. The policy was also behest by FP not being mentioned in the budget of the Ministry of Health (Mukaba et al., 2015).

Kayembe et al. (2015) analysed through regression analyses three surveys of health facilities conducted in Kinshasa in 2012, 2013 and 2014. They found that access to health facilities was hampered by the absence of institutional partner coordination, which means that international development partners or religious institutional partners did not coordinate the work among them, thereby creating overlapping aid to health centres. Nonetheless, they found a steady increase over the years documented in the provision of multiple forms of contraception and an increased readiness to provide FP services. Recent research, in 2018, found a relationship between increased political and donor commitment and contraceptive prevalence in Kinshasa and prevalence that showed a rise from 18.5% in 2013 to 26.7% by 2017 (Kwete et al., 2018). A survey targeting 1,555 health facilities in 11 provinces of the DRC (Mpunga et al., 2017) revealed a low rate of availability and quality of FP services in the country, and unequal distribution of services – especially in rural areas. To date, there

has been no country-wide survey on the coverage and prevalence of FP.

A lack of stocks and inadequate stock management has been a consistent finding in research. The Family Planning Watch[35] conducted in the urban and rural areas of Kinshasa and Katanga provinces with 1,294 public health facilities and registered pharmacies, concluded the following:

1. One in three public health facilities in Kinshasa and Katanga had male condoms, oral contraceptives and injectable[s] available; availability was much lower in Katanga rural areas than urban areas.
2. A quarter to a third of drug shops in Kinshasa had oral contraceptives and emergency contraceptives available; 15-25% of drug shops in Katanga had these methods available; availability was generally much lower in rural areas in both Kinshasa and Katanga.
3. In Kinshasa more than 40% of public health facilities had implants available and a quarter had IUDs [intra-uterine devices]; in Katanga about 15% had implants and 10% had IUDs.
4. LARC [Long-acting reversible contraceptive] availability in the private sector was generally very low in both Katanga and Kinshasa (FPwatch Group, 2016, p. 80).

According to Mugisho (2016), female condoms are one of the 13 contraception methods used in the country and are listed as essential medicine. However, this contraceptive method is not known by the majority of the population and is targeted chiefly at sex workers and military wives. It is, moreover, a good deal more expensive than male condoms, and there is very little stock in the country (Mugisho, 2016).

Private pharmacies have thus far had no role in the DRC health policy, but recent research suggests that there is unmet potential in the sector. Research among 73 pharmacies in Kinshasa found that 90% of them were helpful and knowledgeable in responding to clients asking for emergency contraception, but that there was a serious lack of stock (Hernandez et al., 2018). These private pharmacies could therefore be envisaged in the next FP strategy as a partner of government in contraception delivery (Hernandez et al., 2018).

A group of scholars used the DHS survey to measure the birth intervals of women in the DRC through the Bahesian Geographical statistical measurement method (Chirwa et al., 2014). They found that short birth intervals of less than 24 months, which are a factor in maternal mortality and child-under-five deaths, accounted for 30.2% of intervals for the age group 15–49, and a higher prevalence of 38.7% for the age group encompassing 18–24-year-old women of reproductive age. In rural areas, exclusive breast-feeding and low education levels were associated with a higher risk of short-term birth intervals. Younger women had higher a risk of short-term birth intervals in both North and South Kivu (Chirwa et al., 2014).

There has generally been a lack of research on the use and preference of contraceptives from the point of view of women and men. One piece of research in Kinshasa used focus groups to explore barriers to the usage of contraception in urban settings (Muanda et al., 2016). The findings listed the main barriers as follows:

- the fear of side-effects
- socio-cultural norms
- the costs of the chosen method
- pressure from family members to not use new modern methods
- lack of information (Muanda et al., 2016).

Other research found that the availability of mobile phones to communicate with friends and relatives, was related to a reduction in the number of unintended pregnancies in 600 households in the Kwango District (Dhakal, Eun and Ho, 2016, p. 5).

In short, while research found some positive trends and identified factors facilitating the use of contraceptives, major obstacles were found in the political decision-making over central and provincial FP budgeting, which were further reflected in the coordination and stockage in the system. Other problems related to embracing FP were associated with the social and cultural response to it. The last-named factor also points to the importance of gender relations in FP in the DRC.

3 Family Planning Watch' (FPwatch) 'is a multi-country research project implemented by Population Services International (PSI) with funding from the Bill and Melinda Gates Foundation (BMGF) and the Three Millennium Development Goals (3MDGs). [...] FPwatch is a response to the Family Planning 2020 (FP2020) goal to enable 120 million additional women and girls to have informed choice and access to family planning information and a range of modern contraceptive methods'. Family Planning Watch DRC 2015, p. 7.

2.4 Gender roles and policy

Pre-colonial gender relations in the DRC are little explored, and seem to vary according to social groups. Whereas, among some ethnic groups, women held positions of power and had some degree of economic independence and autonomy, others did not allow women to keep or be near the cattle, due to their being considered unclean while menstruating (Freedman, 2015). In most of the DRC, women's families were bestowed with a dowry upon marriage. Although this meant that girls were seen as surplus value for their families, it also meant that they were effectively 'bought' and were considered the property of their husbands. Dowry systems have survived into the present day, including in urban areas.

Under colonialism, the Belgians promoted western European gender roles, whereby women were primarily considered as housewives, through the introduction of the Family Code and the practice of Christianity (Freedman, 2015). Especially in the cities, single-unit Catholic families became the norm.

During the war years, 1996–1997 and 1998–2002, women in eastern DRC experienced intense sexual violence and rape by rebel groups. Sexual violence did not end with the wars' conclusion, and continues to be highly prevalent with a shift in perpetrators towards civilians. The strong inclination of international actors to respond to these outbreaks of sexual violence has had the unintended consequence that other issues of (reproductive) healthcare have been neglected (D'Errico et al., 2013). An illustration of this dilemma is the situation of women requiring fistula surgery in the hospitals of Panzi (Dr Mukwege's hospital) and Heal Africa. Although it is widely believed that their conditions are caused by violent rape, both hospitals report that an estimated 95% of the cases in fact concern complications in childbirth (Hilhorst and Douma, 2017).

Abortion has been used as a contraception method globally, though it has also constituted a major battleground over the rights of women to control their bodies from the 1970s onwards (Petchesky, 1986). Abortion in the DRC was illegal until July 2018. A law proposal on sexual reproduction was presented to the Congolese Government in June 2015. In July 2018, a coalition of national women's organisations – including the Coalition on Non-Desired Pregnancies, the Association for Family Wellbeing and INGOs such as Médecins du Monde, International Rescue Committee and Pathfinder – lobbed for the law to be approved by the government.

> ***Congolese Women can now legally access abortion under the following conditions – in cases of sexual assault, rape or incest, or when the continuing pregnancy would endanger the mental and physical health of the woman or the life of the woman or the foetus***[4]

Beyond some isolated studies on sexual violence, there continues to be a lack of systematic, historically grounded research on the development of intimate relations and family life in the DRC. The colonial imagery of the nuclear family unit, as continued by present-day religious and societal norms, did at best partially reflect the lived reality of those times. However, there are extreme levels of poverty in the current urbanised post-conflict DRC. Here, nuclear family units may be a norm but there are many other realities too. Conflict and migration related to mining are among the factors that have created a large number of de facto divorces, even though a marriage may continue in name in the case of an absent husband. In addition, there are high levels of transactional sex. Transactional sex is very common in many milieus – including among poor urban households, petty traders, educational institutes, professional life and religious communities. Although it often includes elements of affection, young women are especially vulnerable to violence and exploitation in these relations (Isumbisho et al., 2016).

Since independence, DRC has signed up to most of the relevant international resolutions pertinent to women, starting with the Convention to End all Discrimination against Women, UN Security Council Resolution 1325, the Maputo and Southern African Development Community (SADC) protocols and the UN SDGs. These international policies have also been translated into modern national laws and decrees in order to promote gender relations that mirror international policy. However, there is little awareness of these laws in the country at large, and huge disparities continue to exist between men and women (Kyamusugulwa et al., 2018). Women are also reported to have secondary status in household decision-making (Freedman, 2015; Hilhorst and Bashwira, 2014).

4 http://www.safeabortionwomensright.org/democratic-republic-of-congo-legal-access-to-abortion-expands/

It is difficult to find research focused on women's roles within the DRC healthcare sector. Most of the literature concentrates on issues of access to and quality of healthcare, the impact of health services on child and maternal health, and the organisation of the country's decentralised system (Carlson, 2005, World Bank, 2007; DFID, 2014; Newbrander et.al., 2011; Moshonas, 2014). However, there is no gender segregation regarding these aspects of healthcare. Despite the low representation of women in the civil service sector, they have been active in the institutions and ministries that have promoted the health of mothers and children, as well as in Catholic-based organisations dedicated to the promotion of hygiene and health education (Hilhorst and Bashwira, 2014; Chirhamolekwa and Miatudila, 2014). Importantly for the issue of FP, however, women play very minor roles in the hierarchy of the various churches themselves (Kyamusugulwa et al., 2018). Acknowledging the lack of analysis when it comes to the matter of women in the civil-service sector, The DFID report on Payroll Reform in the Health Sector in the DRC concludes that 'the role of women in the Congolese civil service is a massively under-explored subject, which deserves much further study' (DFID, 2016, p. 11).

This literature review presents a diversity of findings regarding FP and SRH provision during armed conflict in displaced populations in the Kivus (North and South) and in the capital city and its surroundings, as well as in other provinces not impacted by war. It discusses the use of certain types of contraception in some HZs in the DRC and the increased prevalence of FP services in general. There is, however, to this day no research that targets the implementation of the Family Planning Provincial Strategy in any of the provinces of the country, or the challenges that governmental and non-governmental actors have in providing such services. Furthermore, there is no research that observes the use of FP services in any province of the DRC by different age groups and the effects that these services, the household economy, the cultural context and religious beliefs have on couples making contraceptive decisions. Our research devotes attention to all those aspects missing in the literature by taking the case of the implementation of the Provincial Family Planning Strategy for the province of South Kivu in eastern DRC. Last but not least, we unpack the way in which SRH information for young people is provided (or not provided) within their families, schools and church sessions. We also observe the ongoing role played by INGOs in improving existing Catholic sessions on SRH for young people to make them more comprehensive, current and gender sensitive.

3 Research methodology

3.1 Methodology, research ethics and access to participants

The primary data for this paper were gathered through qualitative research methods: meetings, interviews and observations with representatives of several governmental and NGOs. These took place in Bukavu, South Kivu, in the territories of Walungu and Kabare South (July–October 2017), and the communes of Kadutu, Ibanda and Bagira (May–August 2018). Most of the interviews were conducted in English, and some of them through translation from French into English. (For the list of the governmental and non-governmental representatives of different institutions met and interviewed, see Annex 1.)

Five focus-group discussions were conducted with healthcare employees and CLOs in the HZs of Kadutu, Bagira, Walungu, Kabare South and the Family Planning Department at Panzi Hospital. In order to do so, written permission was obtained from the Provincial Minister of Health. Answers were not directly recorded because the focus group members did not give permission to be recorded, but responses were written down by the researchers during the discussions. Each focus group lasted 1½–2 hours. Access to members was arranged through the chiefs of the HZs, who were asked whether they wanted to participate in this research. If they were interested, they were asked to invite the main nurse, doctor and pharmacist of the HZ and two to four CLOs. The date and the hour of the focus was decided by the chief of the HZ.

Two focus-group discussions with eight women of reproductive age, 20–40 years, and eight men of reproductive age, 20–52 years old – speakers of Swahili – were conducted at Kadutu and Ibanda HZs. Written permission from the Provincial Ministry of Health, Division of Sexual and Reproductive Health was obtained to conduct focus-group discussions with people from Bukavu at the offices of the HZs. The contents of the focus groups' discussions were drafted by the International Institute of Social Studies (ISS) research team, with feedback given by the Center for Research on Gender Equity and Development at the Institute for Rural Development in Bukavu (CREGED). Both discussions were facilitated by a local female moderator who had been in FP and SRH, as well as on qualitative research methods, face-to-face interviewing, and interviewer and participant power and positionality. As with the healthcare employees and CLOs, the focus groups lasted 1½–2 hours. Access to members was arranged via the female local moderator,

who had, prior to the discussions, interviewed the women and men involved in order to understand their experiences of:

- contraceptive use
- FP decision-making as part of a couple
- services in the health centres.

The moderator then selected the most informative participants and most interesting cases for the focus groups.

Four focus-group discussions were conducted with high-school students aged 16–20 years old. The first two groups came from the communes of Bagira and Ibanda in Bukavu city, respectively, and the third and fourth were sourced from high-schools in Walungu and Kabare North territories, respectively. Each of them had eight students – four girls and four boys. The focus groups were organised in collaboration with the experts of the Provincial Minister of Education in South Kivu. Permission was obtained from the Provincial Ministry of Education to conduct focus groups with high-school boys and girls in order to discuss:

- how they understood gender in their families and society,
- the knowledge on SRH that they received in schools under the subjects of 'Education for Life' and 'Biology'
- their satisfaction (or not) with
  - the SRH sessions
  - their thoughts on what they wanted to do after high-school
  - the number of children they wished to have
  - gender roles that they thought they would perform in their future family set-up.

Again, each focus group lasted 1½–2 hours. To access the high-school students, the two experts of the Provincial Ministry of Education informed the school director about the research intentions and asked the director to put them in touch with the teachers of the Education for Life and Biology subjects. These teachers selected the students who participated in the session. They chose students based on their age and their willingness to participate in the focus groups.

In all, six interviews were conducted with three teachers of Biology and three teachers of Education for Life in the high-schools of Ibanda, Bagira and Kabare North. In addition, two interviews were conducted with an SRH male youth trainer from civil society, and an SRH and FP female trainer from the Catholic church and INGOs.

Face-to-face qualitative interviews with open questions were conducted with 40 young people and with adults of reproductive age: 18–49 years old (for women) and 18–52 years old (for men). They took place from the end of May to the beginning of August 2018 in the HZs of Kadutu, Bagira and Ibanda in Bukavu city. For the purpose of research ethics and methodological choices, interviewing the Bukavian citizens on the sensitive topic of FP decision-making in the family and contraceptive choices was conducted by a local female research assistant. Written permission from the Provincial Ministry of Health, Division of Sexual and Reproductive Health was obtained in order to request the support of the nurses and CLOs of the HZs in facilitating access to local participants. A number of them were selected from the FP clients of the HZs. For the other participants, the local networks known to the CLOs were utilised in order to diversify the study to include the following adults:

- those using private pharmacy services
- those with knowledge on FP from community meetings
- those without FP knowledge per se.

Both the nurses and the CLOs either called former or current clients receiving contraception at the health centre, or went to their family homes to share information on the project and ask if they would be interested in participating. Household members who indicated a wish to participate were invited to for a face-to-face interview at one of the health centres. Before every interview, the local female interviewer informed them about the research and the content of the questionnaire prepared, asked for their consent and assured them of their anonymity. The interviews were conducted in Swahili or French, with answers of the participants being recorded in French and translated into English afterwards.

Observation and note-taking methods were used in the round-table 'Family Planning and Religion Partnering in South-Kivu' discussion, which was organised by the Catholic Diocesan Office for Medical Services (Bureau Diocesan des Oeuvres Medical – BDOM). This took place in cooperation with the Provincial Ministry of Health on 6 September 2017, and within the monthly meeting of the FP Task Force Committee on Logistical Coordination organised by the Provincial Division on Sexual and Reproductive Health (PDSRH) on 15 September 2017. Observation and note-taking were the research methods

used during interviews with the key actors, meetings and focus-group discussions. These drew the findings and analysed gender representation in key policy-making, reporting and administrative roles.

A further method of data gathering took place via desk research to thematically review the written literature on FP in the DRC, and reports from INGOs, provincial institutions or those from local religious institutions.

For this research, we complied with the EU's General Data Protection and Regulation (GDPR) procedures in order to respect the anonymity of the research participants. Prior consensus was also obtained from all participants regarding the content of the questions, and it was agreed before the interviews that they were free to not answer all of them. It was also outlined that, in cases where they did not feel comfortable with the questions being asked, they could decide to discontinue the interview.

We quantitatively measured some of the data that had been gathered qualitatively during focus-group discussions and face-to-face interviews with young people and adults of reproductive age. The data is analysed in IBM SPSS Statistics 25.

3.2 Research location and the characteristics of adult and high-school student participants

South Kivu is one of the 26 provinces of the DRC and is located in the eastern part of the country bordering Rwanda, Burundi and Tanzania. According to data from the South Kivu Population Office, in the first quarter of 2016, the province had a population of 6,442,178, of which 884,794 were living in the city of Bukavu and the rest in surrounding territories. Bukavu hosts a large number of internally displaced people who arrived from the territories of South Kivu during the armed conflicts in the 2000s. (Nguya, 2016).

The first group of participants was made up of 40 adults and teenage parents – 17–49 years old for women and 17–57 years old for men – with whom we conducted qualitative face-to-face interviews in the Bagira, Ibanda and Kadutu communes (20 in Bagira, 17 in Ibanda and three in Kadutu). This group displayed a gender balance of 20 men and 20 women.

A second group is made up of participants to two focus-group discussions with people that are in union– one with eight women was conducted in the HZ at Kadutu Commune on 20 June 2018, while the other, with eight men, was conducted in the Ibanda Commune, Chai Health Centre, on 21 June.

Table 1 presents the age of the first group of participants plotted against their gender breakdown. It shows that:

- 15% of the participants – four women and two men – were teenagers between 17 and 19 years old – young parents mostly living with their own parents and their child.
- 12.5%, or two men and three women, belonged to the age group of youngsters between 20 and 24.
- 47.5% of participants, or ten women and nine men, belonged to the group who were 25–35 years old.
- 20% were in the age group between 36 and 50 years old – six men and two women.
- 5% – one woman and one man – belonged to the age group 51–57 years old.

The last category of adults was selected to observe the differences with other groups in terms of changed attitudes towards ideal family size, along with FP and contraception usage, and the role of religious beliefs and gender roles in the family.

Table 2 presents the age versus the gender breakdown for the second group of adults whom we held focus-group discussions with. In this group, women belonged to the age range 20–40 years old and men belonged to the age range 26–57 years old.

In the first group, men, adult women and young fathers and mothers answered a list of questions divided into three sections for the questions for the age groups. During fieldwork, we divided participants into three

Table 1: Ages of the face-to-face participants *gender-breakdown cross-tabulation

Count		Gender breakdown		Total
		Men	Women	
Age of the participants	17–19 years old	2	4	6
	20–24 years old	2	3	5
	25–30 years old	4	6	10
	31–35 years old	5	4	9
	36–42 years old	4	1	5
	43–50 years old	2	1	3
	51–57 years old	1	1	2
Total		**20**	**20**	**40**

age groups: teenagers, 17–19; young adults, 20–34; and older adults, 35–49 for girls and women versus 17–19, 20–34 and 35–57 for the equivalents for men. The first section contained general questions about the participants' family composition and history. The second was about the FP and contraceptive usage of the participants. The third section asked about their socio-economic position and solicited opinions on how the household economy, religion and society/culture influenced their opinions on FP. Through these questions, we aimed to understand how FP is experienced by the parental generations of the participants in comparison with the participants' own FP and what influences FP today for South Kivians more widely.

The main objectives of the focus groups were:

- to understand how local adults felt about FP, and whether they considered it is important for them and why
- to appreciate the participants' experiences with contraceptive methods (traditional, natural and new), and along with the impact of contraception usage throughout the course of their lives;
- to obtain a picture of the FP services provided by health centres from the perspective of service users
- to gain knowledge about the channels of communication through which these Bukavian citizens received FP services, and whether and how they were involved in any kind of communicative participation to express what they would really need in terms of contraception and FP service provision.

The third group of participants were students of the high-schools in the territories of Walungu and Kabare North, Ibanda and Bagira Commune (See Table 3). They were asked about:

- the quality of information they had received on SRH education in school
- the transfer of knowledge about changes in puberty and SRH from their parents
- the gender roles in their families
- how many children they would like to have in the future
- whether they had received information on SRH from local non-governmental organisations (NGOs) or INGOs.

The main objective of these focus groups was to observe the quality of SRH and the impact of education about it

Table 2: Ages of the adults of reproductive age with whom we had focus-group discussions *gender-breakdown cross-tabulation

Count		Gender breakdown		Total
		Men	Women	
Age of the participants	17–19 years old	2	0	2
	20–24 years old	1		2
	25–30 years old	3	4	7
	31–35 years old	3	2	5
	36–42 years old	0	1	1
	43–50 years old	0	1	1
	51–55 years old	1	1	2
Total		10	10	20

that students had received in school, their knowledge on gender, their thoughts on the future family sizes they desired and the gender roles they believed they themselves would perform in their future families. The four focus groups each consisted of four boys and four girls, ranging in age from 17 to 20.

The representatives of the governmental institutions and NGOs were asked about

- their role in the province regarding demand creation through the dissemination of information about FP and SRH
- their role in service delivery and the provision of contraceptives.

The governmental representatives were separately asked about the types of cooperation that they had with

- INGOs
- local civil-society and religious leaders
- health centres
- the way in which they measured citizen satisfaction
- their strategies to gather information from citizens about the services delivered.

The non-governmental representatives were asked about their cooperation with each other and the government regarding

- policy-making
- service delivery
- monitoring and reporting.

Table 3: Types of families emerging from the 40 face-to-face interviews

	Frequency	Percent
Married	23	57.5
Second-marriage	5	12.5
Single	3	7.5
Widow/widower	1	2.5
Live with my parents-in-law and my partner	1	2.5
Polygamy 2 families	1	2.5
Live with my parents and my child/children	4	10.0
Separated	2	5.0
Total	**40**	**100.0**

4 Family planning within South Kivian households

We cannot talk about FP policy for South Kivu households and how it effects adults and young people unless we understand the composition of these families and the typology, economy, cultural contexts and religious beliefs that shape them.

In order for us to understand the most relevant and easily embraceable type of FP policy in South Kivu, we analysed within two generations – the participants' and that of their parents – the types of families they had created, the number of children they had, the gender-role dimension within these families, the age at which they had their first child and the planning for their this and their subsequent children.

4.1 Family composition and gender-role dimensions in child rearing and upbringing in South Kivian families

One of the objectives of the face-to-face interviews with South Kivian adults who were parents, whether in a union or not, was to understand their original family typology and the types of families that they themselves had created.

Table 4 shows that 17 of the participants, or 42.5% of them, came from polygamous families. More women and girls than men and boys were raised in polygamous families: ten versus seven, respectively. Tables 3 and 4 show the change in family life within one generation. Whereas seven men were raised in families where the father was in a relationship with more than one woman, only one of these men was in a polygamous relationship with two. This man felt the need to justify his polygamous situation (without prompting) by blaming his first wife's alcoholism, indicating that monogamy has rapidly become an acceptable norm.

Divorce is more common today than during colonial times. We see in Table 3 that five participants, or 12.5%, have a second marriage, and two of them are separated. Out of 40 participants, only 57.5% of them are still living with their first spouse. Note that the polygamous participant mainly lived with his second wife.

Other research questions for the participants were related to the role of both parents in their upbringing, and also the role of the participant and their partner/wife/husband in bringing up their own children. This was to assess whether gender roles, within the household or outside of it, played any role for participants in dividing childcare duties in the home, reducing women's time

Table 4: Gender breakdown *type of original family in which the interviewee was raised, cross-tabulation

Count		Type of the family the interviewee was raised				Total
		Monogamous	Polygamous father, two partners	Polygamous father, three partners	Polygamous father, more than three women	
Sex segregation	Men/boys	13	4	1	2	20
	Women/girls	10	8	0	2	20
Total		**23**	**12**	**1**	**4**	**40**

in order for them to finish their education or participate in the labour market. As t SRH extracurricular training offered by INGOs to high-school students and young people now includes gender as a comprehensive element, it is interesting to look at this data in order to understand just how gender sensitive parents in DRC today – and the parents of the future – actually are.

Half of the participants credited their mother with the main role in their upbringing, while 32.5% stated that both their mother and father were involved (see Table 5). We defined gender roles and child upbringing as not only childcare in the house but also income generation to help raise the child.

A 26-year-old mother from Bagira Commune, when asked about gender roles in her parent's family, explained that both parents played a role in raising her:

> ***Financially my father is, for he is the one who works and brings money in the family, [while] my mother looks at the house tasks. It's her who takes us to the hospital when we are sick, prepares food, clean dishes and even is responsible for the education (26-year-old mother of three boys, Bagira Commune).***

A 34-year-old mother of five children, from Ibanda Commune, said the following about her parents in answer to the question about who played a role in her upbringing:

Table 5: Gender role in child rearing at parents' home for our 40 face-to-face participants

	Frequency	Percent
Mother	20	50.0
Father	6	15.0
Both mother and the father	13	32.5
Other family members	1	2.5
Total	40	100.0

> ***Both of them, because my father was not a traveller. He always stayed home and took care of our education and [the fact} my mother [was] a business woman, often absent from home every evening, controlled how we spent the day (34-year-old mother of five children, four sons and one daughter, from Ibanda Commune).***

From this data, we understand that, for South Kivian families in urban areas, gender roles do not conform to clear-cut stereotypes, such as domestic tasks being performed exclusively by women and income-earning by men.

4.2 Incomes from earnings and household expenses

What was the actual income-generating power of our participants? It is interesting to see the connection between income earning broken down by gender, versus the gender roles played in the participants' families (see Figure 1). This question is also important for connecting the time they spent in the home taking care of children with the number of the children in the family and the time women had to participate in the labour market. The more children women had and the more time they had to take to give birth to and care for them, the less time they had left for education and income generating.

Figure 1 demonstrates that, from our target group, women faced significantly higher unemployment rates than men: whereas eight women were jobless, only two men were unemployed. There were two male and four female teenage parents who relied on their own parents for every expense and also those of their children.

Extended family life was stated by the participants as an important element in how they sustained their livelihoods and raised their children. In table 3 we can see that five participants lived in extended families with their parents, meaning physical care for their children was shared

Figure 1: Employment broken down by gender of face-to-face participants

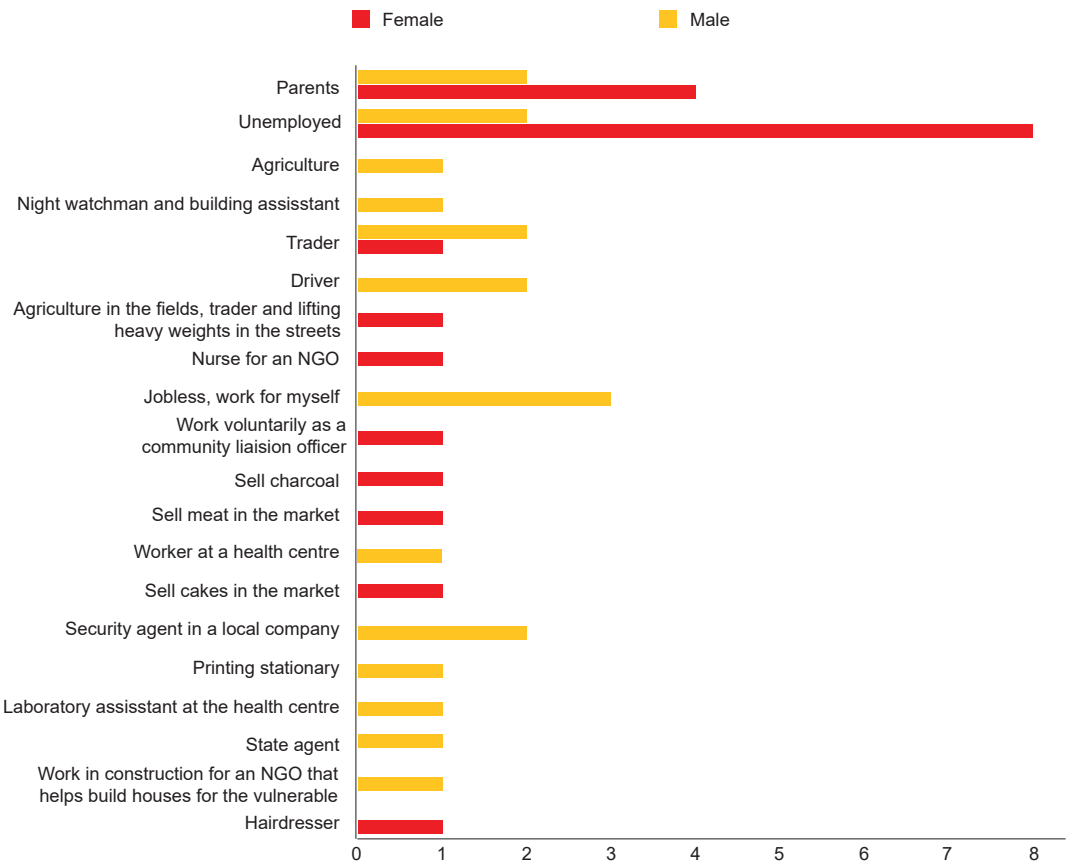


Table 6: Gender breakdown *participants' gender roles in the created family, cross-tabulation

Number		Gender roles in the created family								
		Mother	Participant and parents-in-law	Father	Grandparents and mothers	Mother and the other children	Both the mother and the father	Not applicable	People hired to help	Total
Gender breakdown	Men	7	0	0	2	0	10	1	0	20
	Women	9	1	1	5	1	2	0	1	20
Total		**16**	**1**	**1**	**7**	**1**	**12**	**1**	**1**	**40**

between their parents and in-laws. In Table 6, we can see new clusters of employment and domestic households – such as, for example, the role of other children supporting the mother to raise the children, or the role of grandparents in raising the children for young parents – and we spoke to one woman participant who had hired someone else to take care of household tasks, because both she and the father worked outside the home for long hours.

We also asked the participants about their basic living expenses such as food, rent, children's education, healthcare, and city taxes for water and electricity, along with whether they were able to cover all their family living expenses. We asked this in order to understand the connection between poverty and income generation by both parents in the family and, with the teenage parents, to understand how they thought about FP or the number of children they wanted to have.

Of the 40 people interviewed, only five could cover all family expenses. Three families could only cover nutrition costs, and could not afford to send their children to school. The rest covered the basics of food, clothing, electricity and water services with difficulty. It was

informative to note that when asked for healthcare costs, families favoured traditional medication such as natural herbs over going to a health centre. However, in relation to pre-natal consultations, all women – as well as men – who were asked about their partners declared that they went to the health centre at least once or twice during their pregnancies to check on the gestation's progress.

Participants were also asked whether they thought their household expenses constituted a reason to consider FP and discuss contraception and reducing the number of children they wanted to have. This correlation did not seem strong in the minds of participants.

When participants had more than five children and only one of the partners had a form of income, they would reduce from three meals to one meal per day and cut down on education or healthcare to compensate for various household expenses. Only two participants referred to poverty as a reason to think about and commence FP, with one saying the following:

> ***According to the economy, we plan because we are poor; rich man does not plan. I am affected positively by the culture because children are a wealth and all depends on means. Briefly, we plan because we are poor (32-year-old father of six children, living in Ibanda Commune, Panzi-Kazaroho Quarter).***

Other people seemed to view FP as a separate issue. A 34-year-old woman with five children – when asked how cultural, religious or economic factors influence her decision on FP – said:

> ***For me personally, the economic and social factors don't tell me anything if I want to do family planning, because I do not consider these factors. Even in previous time[s], couples planned in separate beds during [a] woman's fecund period and therefore family planning is good for its own reason and I keep my decision (34-year-old mother of five children, Ibanda Commune, Chai Mukonzi Quarter).***

From our second group of participants during the focus-group discussions, we discovered another dimension for dealing with poverty when families had many children and were not able to provide nutrition for all of them. When they were asked how many children they had, some disclosed that, apart from their own children, they were taking care of and raising one or two children of other family members who were not able to feed them. In Table 7 we see that, from 16 participants in the group

Table 7: Children of other family members that focus-group participants took care of

	Frequency	Percent
None	6	37.5
One	8	50.0
Ttwo	2	12.5
Total	**16**	**100.0**

discussions (eight men and eight women), 62.5% – or ten in number – took care of one or two children, aged between 6 and 13, of other family members.

This finding on the presence of children of other family members indicates that single-unit families frequently become extended family forms. In additional interviews, participants explained that this was happening due to the responsibility of family members to raise the children of other members who could not provide nutrition and other basic needs for their children, because of having too many and no income to provide for them.

Using the extended family as a strategy to care for children makes FP a more complex issue. On the one hand, reducing one's own family size does not mean that one can reduce care for other children. On the other hand, people can rely on their family and hence do not need to make decisions based on their own resource base alone.

4.3 Size of parents' family versus the family size created

The personal histories of the participants in this study illustrate changing family compositions in the DRC. In terms of number of siblings,40% of our total participants reported six to eight, 25% stated that they had nine to 11, 12.5% reported 12 to 13 and, finally, 10% said they had

Table 8: Number of siblings of face-to-face participants

	Frequency	Percentage
1–5 siblings	5	12.5
6–8 siblings	16	40.0
9–11 siblings	10	25.0
12–13 siblings	5	12.5
'Too many': 'My father was a king and had many wives'	2	5.0
15–16 siblings	2	5.0
Total	**40**	**100.0**

15 or more. Only five came from a family of less than five children (see Table 8).

Although many participants reported that their families were not complete on account of them not having reached the end of their reproductive age, it seemed that their family size was significantly smaller. Table 9 shows the distribution of numbers of children, with the largest group (25%) having one child, and one person having nine.

Table 10 shows the number of children of participants, according to their age bracket.

Fourteen women and two men had their first child between the ages 14 and 19 years old. This shows the prevalence of girls experiencing their first pregnancy during their teenage years. This means that 74% of the women had their first child while they were teenagers in school (Figure 2), whereas a majority of the men (nine, who formed 47.5% of the total) had their first child between 26 and 30 years of age (see Figure 2).

4.4 Were first and later children planned?

Examining the need for FP to address unwanted and unplanned pregnancies from the perspective of the research participants and their personal histories is a highly relevant aspect of this research. The first child in the cluster of face-to-face participants in 62.5% of cases (see Table 11) arose from an unwanted pregnancy – and in many cases, this pregnancy resulted from a first sexual encounter. Both men and women, when interviewed, said they did not know how to protect themselves from unwanted pregnancies. In other

Table 9: Number of children of the face-to-face participants

	Frequency	Percentage
One child	10	25.0
Two children	4	10.0
Three children	9	22.5
Four children	2	5.0
Five children	6	15.0
Six children	3	7.5
Seven children	4	10.0
Nine children	1	2.5
12 children	1	2.5
Total	**40**	**100.0**

Figure 2: Age when participants had their first child

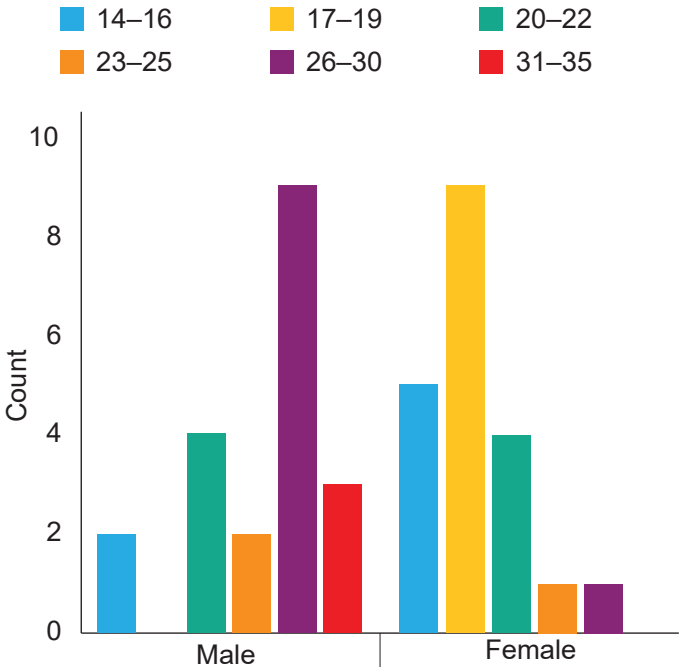


Table 10: Age of the participants: *Number of children, crosstabulation

	Number of children									
Age of the interviewee	**One**	**Two**	**Three**	**Four**	**Five**	**Six**	**Seven**	**Nine**	**Twelve**	**Total**
17–19	5	1	0	0	0	0	0	0	0	6
20–24	3	2	0	0	0	0	0	0	0	5
25–30	2	0	5	0	2	1	0	0	0	10
31–35	0	0	2	1	3	2	1	0	0	9
36–42	0	1	2	1	0	0	0	1	0	5
43–50	0	0	0	0	1	0	2	0	0	3
51–57	0	0	0	0	0	0	1	0	1	2
Total	**10**	**4**	**9**	**2**	**6**	**3**	**4**	**1**	**1**	**40**

Table 11: Indication of whether or not the first child was planned for the 40 face-to-face participants

	Frequency	Percent
Yes	15	37.5
No	25	62.5
Total	**40**	**100.0**

cases, pregnancy occurred during the first months of marriage. When examining these cases, we can see they expose that young people are not well informed on how to prevent pregnancy, and that young couples are not aware of the fact that they can start FP during the first months of their lives together. In the interviews, both women and men gave histories that indicated how unprepared to deal with the new situation they had been as youngsters, and how boys and girls were obliged to marry each other following pregnancies. (Alternatively, boys escaped to the city for a while or girls went to stay with their grandparents in rural areas).

A father of seven children admitted, when asked whether his first child was planned:

> ***No, I had made pregnant two girls at the same time, and both of them stayed at their parents. I or those girls had no means to take those children in charge. Four months later I made pregnant a third girl and I was obliged to marry her and she is actually my wife (54-year-old father of seven children, Bagira Commune).***

This testimony raises the phenomenon of early sexual encounters experienced in ignorance of the issues of safety, respectability and even enjoyability. The quote above is indicative of the prevailing culture in the city, and the subsequent responsibility borne by boys when making girls pregnant. Recent research on forced marriage in South Kivu has demonstrated how the Bashi culture (the main ethnic group in the province) forces teenage girls into marriage if they spend a night out of the house with their boyfriends (Mulumeoderhwa, 2016). Regardless of whether they are in a relationship or have engaged in sexual intercourse, this social convention puts both girls and boys in a difficult position.

The people we talked to in Bukavu told stories about their traditions. When early marriages occurred, for instance, and the girl was found to be a virgin, her mother would be covered in white flour by the girl's in-laws, cousins and other family members. She then walked around the community covered in the flour, as a sign of purity and her ability to preserve the morals of both her daughter and her family. In this way, everyone could see what a good mother she was. (This story was told by three Bukavians: two research assistants and a Catholic religious leader.)

Another woman interviewee shared her story:

> ***No, I was still at my parents when I found myself pregnant at the 5th month of the pregnancy. My parents brought me to my boyfriend's house. We are still married. We had no plan; it was an accident (30-year-old mother of five children, first child when she was 15 years old, Ibanda Commune, Protestant).***

In a number of stories, it appeared that a first pregnancy sometimes led to strategic manoeuvring in order to secure economic support. A mother of ten children – one of whom (not the first one, mentioned here) died – recounted:

> ***No, it was not planned because I found myself pregnant and ran to my grandfather at Birava village and arranged to make love with another man and told him that he was responsible for the pregnancy, just in order to oblige him to support me and pay all the costs of the maternity. When the baby was 10 months [old], I ran back to live now with the true father of my baby. Even today, this man claims the child, because he supported us in the beginning. And this causes much trouble with my partner and even with the child (37-year-old mother of [now] nine children, Bagira Commune).***

While 62.5% of the first children of participants were unplanned, our data showed that 40% of further children were also not planned, while 60% were.

Considering these high levels of unplanned and unwanted pregnancies, the question of abortion naturally arises. Abortion has only very recently been legalised in the DRC, and only in certain circumstances, yet has also played a role in the stories of participants.

A teenage mother talked about her unwanted pregnancy and abortion:

> ***By myself I have never thought about abortion but one of my brothers suggested it to me, but I refused. According to him I was too young to support a baby (17-years old mother of a 3-week-old son, Ibanda Commune).***

A father with a daughter aged two related his story:

> ***Yes, I suggested abortion; she refused because she was afraid of dying or losing her uterus; then I had to run away [to avoid] being thrown in the prison (18-year-old father of one daughter, two years old, Bagira Commune).***

Although the stories of the teenage mothers and fathers interviewed showed an awareness of abortion, none spoke of induced abortion. Earlier research involving 328 high-school girls in Goma, near the DRC's border with Rwanda, showed that 9.8% of them had had an induced abortion and 46% knew where to obtain one. Despite knowing the risks to their lives, 23.8% of the girls interviewed in the study said that they would consider an abortion (Paluku et al., 2010).

FP was usually only considered later in the development of families. A woman who had had a first unwanted pregnancy talked about other pregnancies:

> ***For the second pregnancy, I found myself again pregnant. We didn't plan. I started planning from the fourth pregnancy. After the birth of my fourth child I started problems with my husband. I saw that if I went on making children, I would have the risk of having problems with the children's number, so I [opted for] family planning. I decided alone without telling him and, after three years, he began suspecting me and making trouble. I was obliged to stop a bit and I conceived with no problem. But after this child's birth, I went back to the health centre to receive family planning again (30-year-old mother of five children, first child when she was 15 years old, Ibanda Commune, Protestant).***

This last story indicates women's struggle with planning the number of children they want to have, and how they seek out new contraception methods to allow them to plan safely and achieve their desired number.

4.5 Contraception usage by adults, and FP access in health centres

Literature on the politics of inclusive development (such as from Hickey, Sen and Bukenya, 2015) has argued about the power of the state in low-income countries to include or exclude citizens from the provision of basic services. Other literature on youth and SRH education in low- and middle-income nations has informed us on young people's exclusion from local FP services when information sessions on contraception are given, and condoms are provided for free, and has therefore advocated the inclusion of young people in SRH educational-policy development (Villa-Torres and Svanemyr, 2015; Denno, Hoopes and Chandra-Mouli, 2015). Taking on board their arguments, this research has aimed to explore whether Bukavian men, women and young people are denied access to FP services in the city's HZs – and, if they are, why this is happening and who is responsible for it. This goal led us to ask all our participants whether they enjoyed free access to FP services in their health centres, and/or whether they felt judged or excluded.

In Figure 3, we present the gender breakdown of access to FP services in the health centres, while in Table 12 we present the percentages of access to these services without a gender breakdown.

Half of the participants said they used the services of the health centres, with these people saying they were generally pleased with the service. A total of 40% of

Figure 3: Gender breakdown of experiences of access to health centres

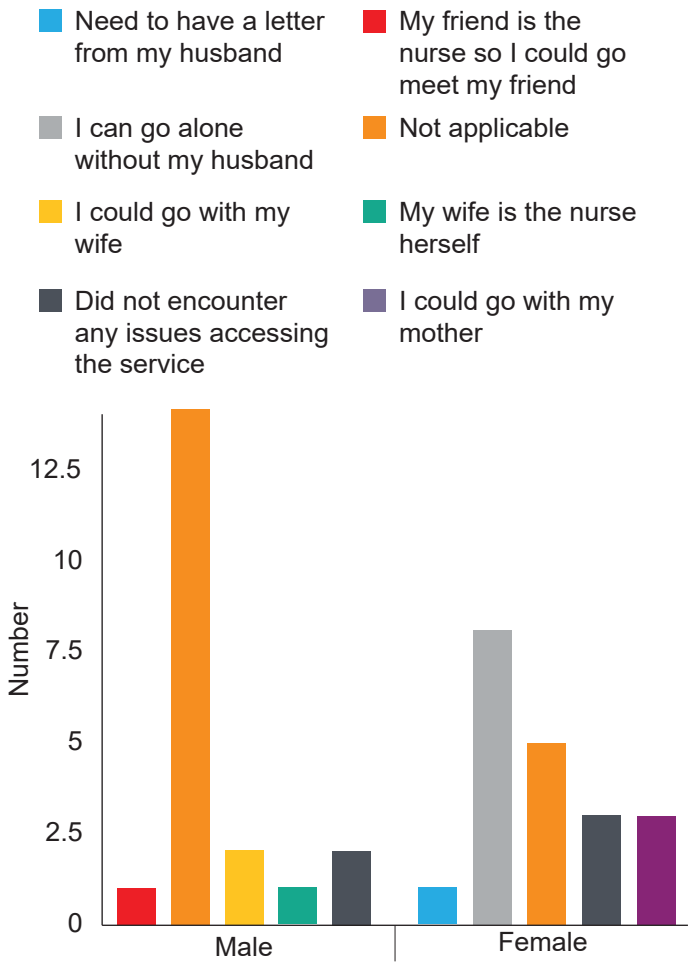


Table 12: Place where the participants learned about SRH

	Frequency	Percent
School –Biology class	8	20.0
Health centre during pre-natal consultations	2	5.0
School – Biology as well and Education for Life classes	5	12.5
No information anywhere	6	15.0
Both school and church	1	2.5
Youth clubs in the church	2	5.0
Mother's group in the church	1	2.5
School – Moral Education, Sociology and Biology lessons	2	5.0
School – Biology as well as Education for Life and environmental subjects	1	2.5
School – only in Education for Life subject	5	12.5
Church	4	10.0
Older sisters and brothers	1	2.5
School and classmates (anecdotal)	1	2.5
Friends and hospital	1	2.5
Total	**40**	**100.0**

Table 13: How face-to-face participants accessed the health centres

	Frequency	Percent
I need to have a letter from my husband	1	2.5
My friend is the nurse, so I could go to meet them	1	2.5
I can go alone without my husband	8	20.0
Not applicable	19	47.5
I could go with my wife	2	5.0
My wife is the nurse herself	1	2.5
I did not encounter any issues [in terms of] accessing the service	5	12.5
I could go with my mother	3	7.5
Total	**40**	**100.0**

Table 14: Type of contraception that face-to-face participants were using during the research period

	Frequency	Percentage
None	15	37.5
Combined or mini pill	3	7.5
Depo provera	6	15.0
Arm implant	5	12.5
Cycle necklace	5	12.5
Calendar	6	15.0
Total	**40**	**100.0**

women went alone without their husbands, with this not creating any problems for the healthcare employees concerned, whereas two men told us they went with their wives (see Table 13). Fourteen out of the individual 20 men we spoke to said they did not attend the health centres (70%), compared to five women who gave the same answer (25%) (see Figure 3).

A high number of both men and women, 77.5%, indicated they had knowledge of new and traditional contraceptive methods.

Among the participants:

- 37.5% used no contraception method at all
- 27.5% of women used Depo Provera (injectable contraceptive) or an implant
- 7.5% of women used a pill
- 27.5% used the natural-method calendar with the help of a cycle necklace (table 14)
- there were none who used condoms.

Figure 4: Cycle necklace (collier du cycle)

Photograph taken by Arla Gruda in August 2017 at the Bureau Protestant des Oeuvres Medical, Protestant Office of Medical Services (BYCOP)

A cycle necklace (usually referred to internationally as 'cycle beads') is a colour-coded string of beads representing the days of the menstrual cycle to help an individual track cycle days. The data collected shows there was extensive knowledge on contraception in South Kivu, and increased use of new contraceptive methods.

4.5.1 Inclusion of men

During an interview with the Director of the Family Planning Department at BDOM, we were informed that the guidelines from the Provincial Ministry of Health state that both husband and wife should be present in the health centre during an FP information session, or that the woman should have a letter proving consent from her husband. However, there is flexibility in this rule – as the interviews demonstrated.

Both the face-to-face interviews and the focus-group discussions provided stories indicating that FP and contraception use are regarded as issues mostly for women. Men are involved in deciding about FP at home, but not so much at the health centres. From focus-group discussions with the eight men in the Chai Health Centre in Ibanda Commune, men expressed the opinion that FP was offered only for women – and that men should be informed too, and should attend the health centres as well.

A 37-year-old man, a father to two children, said during these discussions:

> ***According to me, family planning is only done for women because they receive information when they come to the health centre, and we do not come. So, I think [it] is good that man have information too and they also come to the health centre.***

A father of one, of the same age, shared the following with the other participants in the focus group:

> ***The first time I heard from my friends about family planning and contraception. Later on, I heard in the health centre. I have heard also about tubal ligation[5] [and] that if women later on want to have a child, it becomes difficult. I got this information from another man so I thought I would rather come [to] the health centre [myself] and ask [for] information. I was advised and informed about different contraception methods. They told me every person is different and some bodies can take certain types of contraception [and] others not. I now have clear ideas.***

In the focus-group discussion, another 27-year-old man – with two children – remarked to the other members:

> ***Here we are only men, but if I come here alone and I [find] that only women are in the centre, I do not want to be here, because I would start thinking why I should be here; this is their business. So, I think the best way would be to mix both men and women for sensibilisation.***

4.5.2 Inclusion of young people

The young people we spoke to generally felt excluded and unwelcome in the arena of FP. Whereas there was some reported flexibility over the required presence or consent of husbands, teenage girls said they were told they would have to come to the health centres with their mothers.

This was also related to marital status. A total of 48.8% of the participants thought that being married led to easier access to the health centres, compared to being single, whereas 22.6% of participants thought there was no difference.

A young man recalled feeling judged by health-centre staff when he was single:

> ***Yes, I felt judged because when I went for the advice, I was a single man in a group of women and people***

5 "Tubal ligation is a 'surgical procedure for sterilisation in which a woman's fallopian tubes are clamped or blocked and sealed, either of which prevents eggs from reaching the uterus for implantation'. Online resource Wikipedia: https://en.wikipedia.org/wiki/Tubal_ligation

> ***wondered what I came to look for (25-year-old man, father of three children, Bagira).***

A young woman of the same age thought that being a teenage mother meant exclusion from FP services:

> ***First, being a teen mother is a shame and second being a young mother, one feels herself excluded by the family planning services (25-year-old woman, mother of three children, Bagira).***

Overall, the numbers and the stories pointed to positive experiences at the health centres for married couples, although men did not seem to be at ease with the idea of going there alone. Health-centre employees, on the other hand, were not so welcoming towards single people or teenagers. During an informal meeting with the former Director of the Association for Family Planning in South Kivu, Julie Kasigwa Kalehe, one participant disclosed the following experience with regard to some health-care employees:

> ***If a 16-year-old girl would approach a health centre, the nurse would immediately tell her: 'What are you doing here? Go to school and study. Sex is not for you.***

Out of the 32 high-school students aged 16–21 who were interviewed in Bagira, Ibanda, Kabare North and Walungu, the only one who had been to a health centre was a 19-year-old teenage mother. She had gone there with her mother for pre-natal consultations.

In the activity plan for the NMSSFP for 2014, the government aimed to include young people and unmarried adults in its provincial-level strategies. However, the information received from the adults, young people and high-school students interviewed in this study proved that there is still much to be done in terms of communication – both with these population target groups and with health-centre employees.

5 Challenges of family planning and SRH service delivery from the perspective of service providers: governmental institutions and NGOs

In this section, we will discuss the presence of governmental and non-governmental actors in providing FP services. We will bring data findings related to the two main challenges facing strategy implementation:

- demand creation
- stock management.

We also review FP from three perspectives:

- governmental and international development politics
- religious ideology
- local cultural perception.

The Catholic church plays a role in developing and leading in Education for Life and SRH for young people and young couples, both in schools and in the church. Based on this, we will discuss the new role that international organisations are now playing in the DRC, and South Kivu, to support the Ministry of Education and the Provincial Ministry of South Kivu in updating the Education for Life curricula with contemporary information on SRH for young people.

5.1 The governing institutions of family planning in South Kivu

There are two types of FP governing institutions in South Kivu: governmental and non-governmental. The PDSRH (Provincial Division on Sexual and Reproductive Health) has coordination, administration, monitoring and supply roles in HZs, pharmacies connected to HZs, health centres and hospitals. The operation of governmental institutions takes a cyclical form where all the structures are connected to one another, exchange information among themselves and feed that information to the PDSRH. Non-governmental organisations (NGOs) have an autonomous role; they include:

- local religious institutions (LRIs);
- religious hospitals;
- 'umbrella' INGOs, operating through local INGOs;
- women's religious associations;
- international donors; and
- local CSOs – mostly women and youth CSOs.

These institutions do not have leading bodies to coordinate their work, or a cycle of cooperation or information exchange on sexual and reproductive health rights (SRHR) and FP. LRIs and INGOs cooperate with the PDSRH through the Logistical Committee on Family Planning. Every month, this Committee brings together representatives from all

INGOS, UN organisations and LRIs that have active SRHR and FP programmes (Logistical Committee meeting observation in September 2017).

Personnel for SRH are trained on new contraception methods, side effects and how to communicate and consult with couples who want to access the service through the Health Development Committee (Committee Development de Sante – CODESA).

The NMSSFP (2014–2020) sees LRIs – or, as they call them in the strategy document, 'faith-based organisations' – INGOs and local CSOs as their partners in strategy implementation. From our interviews with the representatives of the BDOM and the Protestant Office of Medical Services (BYCOP), we were informed that their main role in FP lies in delivering training in 12 health centres or six HZs in the province of South Kivu (BDOM) and in the provision of ten types of contraception in six HZs (BYCOP).

The role of local women's CSOs, of which we found very few, in relation to SRHR is almost invisible. However, two women's associations were active in the province with temporary projects on SRHR and FP. These were represented by Viviane Sabahire Maramuke, coordinator of Solidarité des Femmes pour le Développement Integral (SOFEDI) and Julie Kasigwa Kalembo, who was Director of the Association for Family Planning at the time of the interview. (The association was closed a few months later, due to lack of funding.) Their targeted audiences were young people in Bukavu city; CODESA members and health-centre nurses, whom they trained up; and the wives of military officers, to whom they provided FP knowledge and female condoms.

Interviews with representatives of INGOs operating locally informed us that their role in FP services lay in capacity-building through training, as well as in delivering contraception in HZs. They told us that I+Solutions assists the PDSRH to identify the chain of supply. South Kivu has 36 HZs, but none of the INGOs or RLIs operate their health programmes in all of them. Each INGO operates in between four and eight HZs, where SRH and FP are integrated into healthcare support for two, three or five years.

5.2 Contraception stock management: how contraception price and donation in health centres relate to payroll reform

One of the objectives of the NMSSFP is to 'develop and strengthen an efficient logical system to manage contraceptives' within FP2020. Despite belonging to one of the DRC provinces that has established a positive model for FP coverage (NMSSFP, Mpunga, et al., 2017), South Kivu was, by June 2017, still struggling with setting up a digital-monitoring system to quantify real need for contraception and stock management (report on FP-South-Kivu, 28 June 2017). Our qualitative interviews, meetings and focus-group discussions with representatives of governmental institutions, INGOs and RMIs revealed various issues that hampered contraception stock management in the province.

What sounded to the PDSRH like a technicality related to 'bad databases of HZs, missing some information on supplies in HZs and lack of technical support for HZs by the National Program for Sexual and Reproductive Health (NPSRH)' (report on FP-South-Kivu, 28 June 2017) for I+Solutions was actually related to, as one interviewee explained, 'lack of donor coordination and financial payroll for health care employees, leading them to have the eye on contraception'. By this, he meant that in the months he was not paid he would sell the contraception available in the clinic to obtain an income. We don't know how many of the participants in the research paid for their contraception, but interviews revealed that many were not aware that contraception should be provided for free.

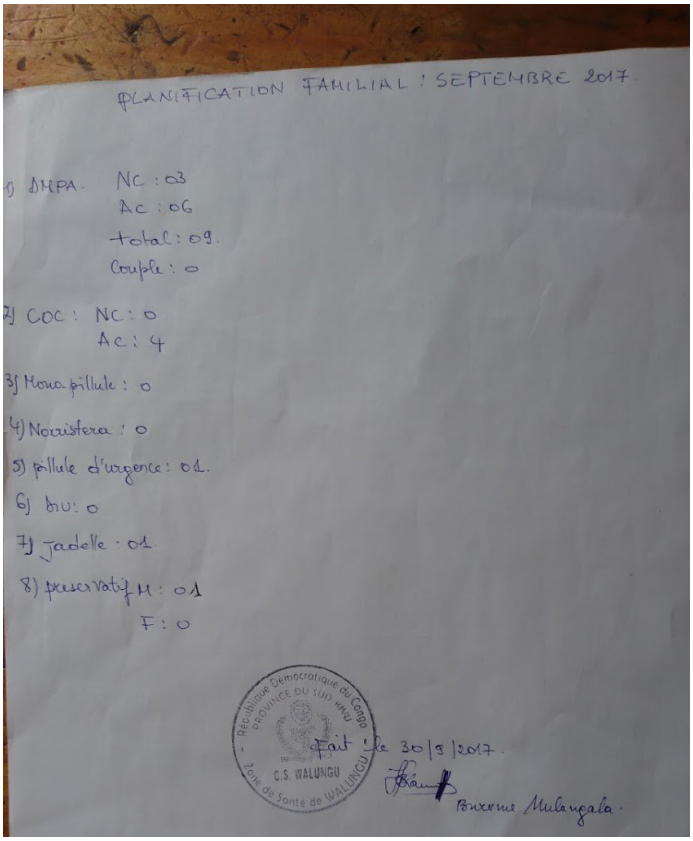
On the other hand, for healthcare employees in the HZs of Walungu and Kabare South territories, the problem with digitisation of data lay 'in power cuts, and lack of office supplies to print the documents' (focus-group discussion with healthcare employees of Walungu HZ). In the Walungu HZ, difficulties in carrying out digital reporting necessitated hand-written documents of the type shown in Figure 5 having to be physically transported to the PDSRH by trusted individual drivers of mini-buses that travelled between Walungu and Bukavu city each day. Lack of financial investment by the government in logistical infrastructure therefore hindered healthcare employees' reporting of contraceptive use.

Such problems with efficiently monitoring contraceptive stock poses a challenge for both the PDSRH and I+Solutions, which assists the former in identifying the chain of supply.

In one of the meetings where data was discussed, a PDSRHR assistant technician in charge of data gathering and analysis, responded regarding its reliability:

> ***If we check in the health zones, we will see some disparities; some health zones have more than what***

Figure 5: Cycle necklace (co Report on the usage of contraception for September 2017, from Walungu Health Zone llier du cycle)



Note: picture taken in the first week of October 2017

> ***they should have when others don't have anything in stock. That is the problem we have to deal with. How [do we] equilibrate the situation of contraceptive stock in all the health zones of the province? (assistant technician, PDSRHR)***

To reduce overstocking in some HZs, the UNFPA began collaborating with the PDSRH to use the latter's stock-monitoring system to order contraceptives, instead of providing them directly to some of the HZs, as it had done before 2017.

The person in charge of the UNFPA programme in South Kivu explained the functioning of the exchange of information on contraception stock in detail, elaborating on its expiry or movement from one HZ pharmacy to another, and how the system had been changed due to a lack of transparency:

> ***One of our FP Projects is the 3C (Commodity-Chain-Care), financed by the Ministry of Foreign Affairs of the Netherlands and UNFPA. This project [supplies] health zones with SRHR/FP kits and medication. It is a programme for North and South-Kivu. Whereas, before. we supplied directly to health zones, we now give contraception to PDSRH. Health centres and hospitals send their requests to health zones, and these [then] report the demand to PDSRH. [For] continuity, PDSRH prepares the distribution plan, manages the stock and brings it to the health zones, which have a parallel structure called Depo Farmaceutique. All the medication from here goes to health centres and hospitals.***

When asked about the challenges of data gathering and why the contraceptive stock varies widely between HZs, a member of the FP Task Force Committee listed four reasons:

- There is a lack of donor coordination and wrongful estimates, whereby need is based on the presence of women of reproductive age and, as a result, some areas are oversupplied and others undersupplied.
- There is an absence of administrative capacity in delivering and keeping stock files.
- The lack of training of personnel in stock management is a factor.
- There is a tendency for health personnel who are not paid by the government to retain oversupply for sale instead of reporting it and sending it back.

Stock issues were thus in part related to the payroll system. During August–September 2017, the administrative employees of the Provincial Ministry of Health, Provincial Ministry of Gender and Provincial Ministry of Education were regularly on strike, once or twice a week, to protest against the fact that they had not been paid for the previous six months. The payroll situation was, in fact, the major concern expressed in the focus-group discussions in the HZs of the communes of Kadutu and Bagira (in the city) and in those of the Kabare South and Walungu territories. In Kabare South, nurses reported being payed once in three months, to the tune of $120, and irregularly.

In the Commune of Bagira, the administrative and supervision staff presented other complaints:

> ***Partners only give $10 for transport for supervising staff, but those who continue to do these services are not paid at all. Some staff get CDF2000-5000 [2,000–5,000 Congolese francs – equating to $1.50–3.00] as [a] supplement. We really want help at all levels. We have here a nurse who works more***

> ***than 30 years, the supervisor more than 27 years and the doctor more than 10 years. We do not have a regulated salary. Some international partners provide us with some type of salary when we are recruited for certain projects, but after a while it stops and we continue to be dependent on the salary which we do not get regularly. The government pays us in terms of supplements. (focus group discussion with healthcare employees at Bagira Health Zone)***

It is sobering to think in terms of the challenges of governing FP strategy in the DRC from the perspective of its various local actors. Whereas the provincial Ministry of Health deals with the issues of the contraception supply chain, coordination and monitoring system, local INGOs are aware of overlapping stock in different HZs due to donor non-coordination. At the same time, INGOs can point out that the payroll problems experienced by healthcare employees create space for the latter to use medication provided for free in order to create a salary for themselves. On the other hand, we found that the healthcare employees – the most critical link in the chain of contraceptive delivery – focused on the challenges posed by what the central and provincial governments had failed to provide them in order to allow them to do their jobs, and advocated for the international community to cover for what the government does not provide.

5.3 Communication for demand or communication for behaviour change?

Another objective of the NMSSFP concerns the generation of demand for FP. This is organised via different channels, through modern and diffused approaches (Haider, McLoughlin and Scott, 2011). Different channels of communication are employed by different institutions. The government uses educational manuals and leaflets delivered in the health areas and zones a few times a year for a few days. International organisations use community campaigns with slogans, megaphones and leaflet delivery once or twice a year for one to three days. Catholic and Protestant parishes have the opportunity to deliver communication on FP more often, in their Sunday prayers or during various education sessions organised by the local educational department or women's health groups.

One of the remaining main challenges to FP strategy implementation is the way in which it is communicated to the populace and the subsequent timing. Instead of first training and strengthening personnel knowledge and skills, creating the proper infrastructure and ensuring stock capacity, the provincial government and international organisations began with communication in 2014. The local infrastructure was therefore unable to respond adequately to the demand that this created; where it did respond it caused unintended side effects, which actually raised public concern about contraception usage (interview with Supervisor for Reproduction Health in Kalehe, International Rescue Committee). When asked about the communication strategy, the person responsible for the Health Programme at Swiss Cooperation recalled the campaign's momentum and the problem with lack of infrastructure at that time:

> ***The first campaign on FP in South-Kivu was launched in 2014 in Kabare, when many donors came together to sensitise the community on contraception methods. It was an all-inclusive campaign, which involved all resources from journalists, politicians, and we did have a media coverage strategy. In the local language in Swahili [it] was called "uzazi bora ndiyo wreateleo", meaning "a good birth is the beginning of development". It has been a beautiful campaign with SMS in mobile phones. It was the first time when many donors came together to campaign on FP. The prevalence raised from 9% to 13% after the campaign. The demands were big, but the service was not there (interview with representative of the Health Programme for the Swiss Cooperation, August 2017).***

Due to healthcare employees being insufficiently mobile, the provincial government has created a community infrastructure of CLOs. The key feature of this infrastructure consists of volunteer community members that are appointed as community liaison officer. The structure was created in order to reach every family in the most remote areas with information on FP. The effectiveness of this infrastructure is rather low, because the community liaison officers work voluntarily and are not paid. The other channels of communication used by the government, such as electronic-media campaigns, are sporadic and depict women and men in a union, excluding the young or reproductive-age population who might not be. Therefore, the most effective contraception communication from the government happens in health centres via the consultation sessions.

Out of 40 participants, 10 (25%) had attended community meetings and 29 (about 72.5%) said they are never invited. Meanwhile, only one participant was invited but did not go (see Table 15). This figure shows that CLOs and the community meetings they organise are not popular in the city. One interviewee was of the opinion that those

organising community meetings only invited people that they already knew. This was confirmed by two other participants in these meetings, who happened to be satisfied with the information received.

A mother of one four-year-old child recounted her experience in the community meeting:

> ***I was invited by a community liaison officer of my Quartier. She told me there would be a women's meeting prepared by the health centre with such topics as family planning and the new contraceptive methods. I accepted the invitation. It was a good meeting. There were many women, girls without children and teen mothers. It was prepared by the health centre. We got necessary information on family planning and methods, and at the end they showed us where to find family planning services. The door is always open to everybody (23-year-old mother of one child, Protestant health centre, living in Ibanda Commune, Muhungu Quarter).***

Because the CLOs constitute a new infrastructure, which needs some time to become popular as well as more institutionalised, there needs to be more thorough research to understand the level of outreach that can be achieved.

During the focus-group discussion with two nurses and three CLOs in Walungu Health Zone, we were told about their issues:

> ***Our staff is trained but our problem remains that every few months we have new community liaison officers and also staff members. They move if they are not paid and they go to areas where they are paid (main nurse, focus group discussion, Walungu Health Zone, September 2017).***

The CLOs had their own concerns related to the lack of means to do their job, as well as the non-financial motivation that is typically relied upon when they have to increase the intensity of the meetings with the populace or venture into deeper, more remote areas.

The president of the CLO and other community liaison officers told us:

> ***We have transport costs to move within different areas which are not paid. We need boots during the rainy season to walk in the mountains and fields to reach houses and communities. We need pens [and] notebooks to take notes when we meet people and write down their requests. We work twice per week, or 10 times per month during the hours 10.00–12.00 or 13.00–17.00 (focus group discussion, Walungu Health Zone, September 2017).***

Table 15: Face-to-face participants' participation in community meetings for family planning

	Frequency	Percent
Yes	10	25.0
No	29	72.5
I was invited but I did not go	1	2.5
Total	**40**	**100.0**

Asked how they conduct the sensibilisation of the population, this interviewee explained:

> ***We give appointments to people in a place called Shirika. We select target groups for women, youth and men, and fix a date. We prepare a topic of discussion and then we make discussions on what CODESA trains us [in].***
>
> ***We find the community liaison officers there. Our orientation is to direct the population either to the main nurse or in the hospital. Some methods are only done in the hospitals.***
>
> ***Liaison officers also do it house to house [and explain] each method and discuss their side-effects. Some people come to us themselves (focus group discussion, Walungu Health Zone, September 2017).***

The information gathered highlights the payroll issues facing local healthcare and voluntary community infrastructures, with the requirement for demand creation and behaviour change in FP. Our participants revealed that other pressing concerns related to demand creation involve the role of LRIs, which have representatives in every community and are thus closer to the populace. Before examining the way in which the religious community deals with communicating FP to local population, we will take a closer look at current thinking on FP in South Kivu.

5.4 Voluntary or forced family planning: governmental, church and international-donor approaches

One of the main issues with the form, place and timing of communication for FP is associated with the ethics of

communication – a factor that often goes unmonitored. Aside from the training that healthcare employees and some of the CLOs receive on how to communicate about FP with the population, it was reported to us that the manner of this communication is not supervised, monitored, controlled or reported.

Ever since the Cairo Conference of 1994, FP has been considered a free choice of adults of reproductive ages, and all of them have the right to privacy when receiving advice. Information we received from women trainers in the Catholic church who were engaged daily, with many years' experience of training communities in SRH and FP, indicates that privacy is not respected in some territories and advice is actually given while women are in the plantation fields. This illustrates, furthermore, how women's right to decide on an FP method are 'bought' with material goods – such as a sack of flour or a new bra. An SRH and FP female trainer expressed her concern to us:

> ***Talking about FP, we put accent on the free choice, but people are pushed to make a choice: they are obligated. Donors give the money to the government, but then employees of the government start to force people's consciousness. They give employers a gift when men or women get a sterilization. Doctors who apply IUDs of 5–10 years get $20 per IUD insertion by donors for increasing the number of women who use IUDs, and women themselves get a sack of flour or bra as compensation for using IUDs.***
>
> ***You have to know that the doctors who insert IUDs and have received the money will not remove [them]. Nobody [has done] analysis before to check the bodies of women. The side-effects are heavy.***
>
> ***In some health zones, employers go in the field to talk to women, and convince them to insert an arm implant and give them a sack of flour in return for their good action. And this is what I call buying the consciousness of the people (interview with a woman trainer from the Catholic church, September 2017).***

Representatives of INGOs and governmental institutions frame their ideology on FP as a voluntary choice made by individuals. However, at the local community level, where FP is provided as a service, episodes such as those detailed above are commonplace. Other women Catholic leaders working on FP and LWOs also confirmed, in non-formal settings, that IUDs would be inserted in hospitals for free; however, if a woman suffered side effects, she would have to pay $20 to have it removed.

We learned that what goes unmonitored or unspoken at the governmental and international level is actually at the core of the communication strategy for leaders of the Catholic church and the leaders of the Catholic Health Institution. In the Catholic church it is unthinkable to try to convince or even force a couple to apply FP and the decision-making involved should happen through communication between spouses. We asked the Belgian sister, Maria Mason, who was the leader of the BDOM at the time of interviewing in South Kivu, to give her opinion on FP within church conventions and she emphasised communication between spouses in childbearing decisions at the core of FP:

> ***The value of women is based on having children. So, if we want to limit the number of children in the family, the husband must agree.***
>
> ***This is very important, because in the artificial methods, the work now is more with women than with men. If women will be taking contraceptive methods without their consent, the men will start wondering why their women are not reproducing and the husband will disappear.***
>
> ***All of us agree to deal with FP, but for families it must be on the agreement of the man and the woman (interview with the former leader of the BDOM, August 2017).***

5.5 Natural versus modern methods of family planning: the standpoints of the Catholic and Protestant churches and citizens

Governmental and faith-based services all include modern and natural methods in their services. However, it is clear from our interviews with service providers – as well as in the stories from our participants – that in practice churches continue to have a strong leaning towards natural FP.

We asked the 40 participants to recount whether they had heard about FP within their church and, from the answers they gave, we can see – in Table 16 – that 45% of participants, 18 of them, admitted to having received no such information from the church. Discussing FP through birth spacing, in adult and youth groups, was mentioned by 17.5% (seven participants), with 7.5% (three participants) having received FP information in pre-marriage sessions organised by the church for the young couples before their marriage.

Table 16: Church information about family planning and new contraception methods

	Frequency	Percent
Yes, for birth spacing, but not for contraception	1	2.5
Church does not talk about it, but [discussion does take place] in the Christian Youth and mother groups	4	10.0
Couples session before marriage	3	7.5
Pro-natural methods	6	15.0
No information from the church	18	45.0
Yes in Protestant church	1	2.5
'FP is a sin'	3	7.5
Birth spacing in youth meetings	3	7.5
I do not go to church	1	2.5
Total	**40**	**100.0**

When considering a few responses from the participants, a 24-year-old Protestant man, the father of two daughters in Kadutu's Mosala Quarter, said:

> ***No, the church doesn't talk openly that it is in favour of the traditional and natural methods and it doesn't give any advice on family planning. The church says to have children is God's blessing; one has to make a lot of them, the one who has only two doesn't look like the one who has many of them.***

A 37-year-old Catholic mother of nine children from Quarter B, Bagira Commune, volunteered the following:

> ***Yes and No; the church talks superficially and not during the mass but yes in the mothers' meetings. Yes, because it gives us information that we have to plan naturally, for it is God who provides the children.***

Despite the fact that the BDOM – indeed, the Catholic church in general – is a frontrunner in supporting central and local government to communicate the existence of FP programmes and new contraception methods, it remains firm in expressing its preference for natural FP methods.

We asked the Belgian sister Maria Mason (the former leader of BDOM) and the man who organises the Education for Life programme in the Catholic Parish of Nguba, at the Ibanda Commune in South Kivu, to give their opinion on FP within church conventions. Both initially associated FP with the cultural values of people living in the provinces and with the use of natural methods.

Maria Mason stated her response to the issue:

> ***The local culture here is about respect [for] human beings. In old times men had very hard work and women light domestic tasks. This has now changed. Men do not have to cut trees or do hard work; therefore, the cultural values are changing.***
>
> ***For us as a diocese, even when the couples do not have mutual dialogue, we try to make them communicate together about the natural methods.***

The Education for Life programme organiser in Nguba elaborated:

> ***Talking about family planning, there are two ways of understanding it:***
>
> ***1. Ancestors' point of view***
>
> ***2. The church's point of view.***
>
> ***No one could talk about family planning in old times. It was known but applied in a discrete manner. The man was educated to get children in the right wanted moment. Parents educated men. Through short stories, young boys were told that children could not come one after the other.***
>
> ***In the area here it was told that parents needed to be separated in two different houses. When the mother gives birth, the father goes away.***
>
> ***In the Catholic family, everything was planned, so ladies could not complain. They were separated 6–12 months after childbirth. There used to also be herbs: the Kashisha herb that women took to prevent the pregnancy. This was happening with [the] approval of both men and women. These herbs did not have side-effects. Now they take the contraception pills and we hear side-effects stories.***
>
> ***Now, let us turn to the church point of view, the second viewpoint:***

In my parish, I am in charge [of telling] families not to have children in disorder. Even the order of Papa Paoul the 6th, Jean Paul II, Benua the 16th [Popes Paul VI, John Paul II and Benedict XVI] talks about it. They wrote much about the family; procreation must be done in order. [...] Abstinence is the best way to space births.

At the church level, we do not agree to allow families to have more children without having food. But we need to know how to practice this in order not to have many children (interview with the man who organises the Education for Life Programme, Catholic Parish of Nguba, Ibanda Commune, August 2017).

The views of both the Catholic health institutional leader and the church educational leader therefore chimed with those of the local culture in favouring reproduction – which typically leave communication and decision-making to the husband and wife in their private setting of the home. Although these participants stood firm in their appreciation of natural methods, in their answers, one can sense a need for change and an opening up to new methods – always, however, respecting the free decision of the spouses in the family.

5.6 Church, government and INGO roles in SRH and FP youth education replacing the lack of knowledge transfer on SRH by parents

The role of the church goes beyond the communication of FP in women's or youth groups, or Sunday prayers. It has a long history – since 1976, in fact – with the creation of the first school curricula on Education for Life, which included sessions on SRH.

The Educational Councillor at the Coordination of Catholic Schools in Bukavu informed us about the first SRH curriculum, the 'Education for Life' programme:

[This was] started in 1976 in Kinshasa, in the Central Service of Education for Life (Service Central del Education ala Vie), from the Belgian Nun Betsy Brock. The programme reached Bukavu 20 years later: in 1995 by the Belgian sister Maria-Mason. In 1984, the Ministry of Education agreed to institutionalise this programme as curricular in all the schools of [the] DRC, from first elementary [classes] to high-schools. It proliferated very soon in Catholic schools, and later on in Protestant, Orthodox and Muslim Schools (interview, Educational Councillor, Coordination of Catholic Schools, Bukavu, September 2017).

Table 17: Indication of parents' transfer of SRH and FP knowledge

	Frequency	Percent
Yes	2	5.0
No	31	77.5
Yes; the mother	3	7.5
Yes; the father	3	7.5
Yes; both parents	1	2.5
Total	**40**	**100.0**

We asked the 40 participants to tell us about their experiences of where they learned about SRH. A total of 11 participants, 27.5% of them, mentioned the Education for Life curriculum, including Biology sessions. Just Biology was mentioned by 20% of participants, (eight of them). No less than 15% of the participants had received no information anywhere – and the rest mentioned health centres, school Biology and Environmental or Sociology lessons, elder sisters and brothers, church youth clubs, friends and classmates (see Table 12). We noticed that parental information on SRH was not mentioned by any participants.

When we asked the participants specifically whether their parents talked to them about their sexuality and reproductive health or FP and birth spacing, we noted that 77.5% of participants said 'No' (see Table 17), while the remainder declared that either the mother, father or both parents did indeed transfer some knowledge.

When asked whether some sort of knowledge had been transferred by his parents, a man living in Bagira Commune responded:

Yes, my mother because, till now, she continued to give us information on the family planning and she is against the early and unwanted pregnancy (interview, 29-year-old father of one child, Bagira Commune, June 2018).

A woman respondent also mentioned her mother passing on knowledge:

Yes, my mother was a teacher. She has enough time to educate and tell us openly about sex, and she organises some family walks through which she tells us about all problems of the life, health and family planning and other things (interview, 23-year-old mother of one child, Bagira Commune, June 2018).

Having discussed the issues surrounding communication and demand creation, the data indicates that the school and the church, as the first providers on SRH information, are well positioned to participate in encouraging young people's social behavioural change when it comes to their sexual health and FP. They can do this by additionally taking issues of sexual violence and gender roles into consideration – not only in society at large but also in the future families that many of these youngsters will go on to create.

INGOs are playing a crucial role in refreshing the curricula on SRH with new information, including gender dimension, new contraceptive methods and sexual violence.

New curriculum sessions on SRH and FP have been developed by the Directorate of Family Life and Population Education at School at the Ministry of Primary, Secondary and Vocational Education. In 2013, this department upgraded the Catholic Curriculum 'Education for Life', institutionalised in every DRC school, to the new curriculum: the 'National Programme of Family Life Education' (Programme National D'Education a La Vie Familiale). This update was provided with technical and financial support by UNICEF, UNESCO and the JeuneS3 (Santé, Sexualité, Securité – 'Health, Sexuality, Security') programme of the Ministry of Foreign Affairs of the Netherlands. By September 2017, the Swiss Tropical and Public Health Institute (TPH) In South Kivu was in negotiation with the Education Department of the Provincial Catholic church to update the previous curriculum with the new version. Unlike 'Education for Life', the New Comprehensive Curriculum on SRH includes sessions on sexual violence, early marriages and teenage pregnancies. It also speaks of population reduction rather than birth spacing (interview with Ernest Mendy, Coordinator, JeuneS3 project at Swiss TPH).

CORDAID (the Dutch Catholic Organisation on Relief and Development Aid), through its JeuneS3 2016–2020 project, has created new spaces that train young people in SRH, leadership and personal values – as well as environments where they can express themselves and be heard. Other INGOs – such as Swiss TPH, part of the JeuneS3 consortium – are educating young people in the Comprehensive Sexual and Reproductive Health (CSRH) training module prepared by UNICEF. This incorporates UNESCO guidelines (interviews with the project coordinator, JeuneS3 at CORDAID; and Ernest Mendy, Coordinator, JeuneS3 at Swiss TPH).

A major finding of this research was that FP programmes need to improve the FP information dispensed to non-married young people. The youth programme Jeune3, which is coordinated by CORDAID in consortium with the World Youth Association, Swiss TPH and I+Solutions, is creating some spaces where youngsters are able to ask questions, to inform themselves about SRH and be provided with condoms (interviews with the project coordinators of JeuneS3 at CORDAID and at Swiss TPH).

CORDAID has initiated a programme to train religious leaders and parents in youth education. A pilot project began in February 2018 to coach parents in collaboration with the schools in Miti-Moresa through a pamphlet, 'Where do babies come from?' In this newly published guide from CORDAID, SRH experts explain how parents can respond to 32 questions that might be asked by their children. Another facilitation guide, this time for religious leaders, has been drafted by CORDAID experts: this is a training package being piloted in rural areas of South Kivu. Trainers reported to us that some church leaders believed it was important to break the silence on early pregnancy, in the hope that youth would abstain from sex, and inform young people about the prevalence and prevention of early pregnancy (interview with the responsible health official at CORDAID for the Jeune3 project).

6 Women's role in strategy implementation

The scholarship produced on FP and development relates such programmes to mainstreaming gender equality in low-income societies (Knorr, 2016). Much of the literature discusses FP as a health, educational and economic empowerment programme for women in developing countries (Sedgh and Singh, 2007; Ahmed et al., 2012). The focus on contraception coverage, barriers to contraception and reaching the Millennium Development Goals (MDGs) on Maternal and Child Mortality, has obscured the issues of who decides on FP programmes, who executes them and who delivers their services.

From the start of the implementation of the NMSSFP 2014–2020 in the DRC, 13 contraceptive methods were recognised and – in principle – offered at health centres. Among these methods, only one is for men (the male condom), while the other 12 are for women. Despite the fact that new contraceptive methods are available for women, when implementing an FP strategy provincially and locally, women are hardly present in policy development and implementation.

Out of the 34 people involved in service provision in our research, only nine were women. Further analysis of the representation of women after interviewing a number at various levels indicates that only 19.3% of all policy-making and execution-level positions in the governmental and non-governmental FP programme implementation was occupied by women at the time of our interviews. Further, one of these nine women stated that she belonged to the local-governmental HZ of Bagira in Bukavu city, while two shared that they belonged to INGOs, three to religious institutions and two to local CSOs. Additionally, of these nine women, two revealed they were not Congolese: one was a nun of Belgian origin, directing BDOM, while the other was of American origin, coordinating the Task Force on Reproductive Health for Médecins Sans Frontières.

During our field work in the five focus-group discussions with personnel for four HZs and one Protestant private hospital, we also observed that 100% of the people selected by the chief of the HZ to be interviewed were men. Only at the Family Planning Department in Panzi Hospital did the director invite two men and two women for the interview – the women being a doctor and a communicator of FP advice for couples and women.

Men were thus heavily overrepresented among service providers, and this was even the case for the volunteer CLOs. Only in Kadutu Health Zone were there women volunteers; in the other HZs, the coordinators and CLOs

were all men. Furthermore, only one of these was a young woman, who had just started to act as a CLO. Therefore, the coordinator had the tendency to speak on her behalf instead of allowing her to express her experience as a woman CLO.

Based on our research into the role of local civil society on SRH and FP, we noted that there are very few women's associations working on these issues in the city. Two women's associations that were engaged in SRH programmes in 2010 have since become non-active – and one of these was actually run by two men. Another LWO, SOFEDI, had a programme of SRH training. However, this was a short-term project for the organisation, and reproductive health was not its primary mission. SOFEDI was nonetheless active in lobbying at the central-government level for the 2015 law proposal on sexual reproduction (see '3.4. Gender roles and policy').

There has been some positive movement with regard to bringing gender sensitivity into higher political institutions in South Kivu. A Gender Equality Committee has been created at the Provincial Assembly as a result of the United Nations Development Fund for Women's ongoing efforts to increase the political participation of women in the province, (interview with the project Manager of the United Nations Development Fund for Women, Bukavu). This body is pushing for the organisation of other structures within the Assembly that will be able to formulate a gender-equality policy and thus mainstream gender in order to start raising men's awareness of the issue (report, Provincial Assembly of South Kivu, 2012).

7 Conclusions

This working paper has sought to shed light on the practices and challenges faced by FP in the DRC, with a focus on the province of South Kivu.

A first conclusion we would like to draw is that family life is changing rapidly in eastern DRC. An accelerated pace of change is visible and related to many factors, including prolonged spates of conflict and the region's partly conflict-induced urbanisation. This paper is primarily based on interviews with 40 participants, 20 women and 20 men, with additional focus groups and face-to-face interviews with service providers and local policymakers. Of the 40 participants, 42.5% had grown up in a polygamous family while only one of the reported living in such a family arrangement at the time of the interview. The significance of this change is hard to gauge, especially because today's relationships are highly diverse: 57.5% of our participants were married while many others were divorced or single parents. Participants had been born in a generation still according a high status to large families, and 77.5% of the participants had between six and 13 siblings (see Table 8).

Of the 20 women interviewed, 14 (74%) had their first child as teenager while they were still at school (see Figure 5). A large percentage (62.5%) of first children born to the participants resulted from unwanted pregnancies (see Table 11) and 40% of the subsequent children were not planned either. This leads us to conclude that there is a high potential demand for FP, especially among young people.

The high prevalence of unwanted pregnancies and non-planned children, as well as the early age of first children, not only creates a burden on the older generation to provide economic, physical and emotional support for their new grandchildren and their daughter or daughter-in-law but also encourages forced marriages between the young people involved, which can cause family conflicts and future divorce. The majority of participants could be considered very poor. However, lack of resources did not seem to be an incentive to consider FP – partly because the care for children is easily transferred to other family members in extended-family situations in the DRC.

We found a high level of knowledge of contraception methods among participants (77.5%). Slightly more than half (52.5%) reported using a form of FP, obtained from health centres throughout the province. Modern anti-conception methods were used by 35% of participants, whereas 27.5% used the calendar or a cycle necklace to

monitor their menstrual cycle (see Table 14). None of the participants reported using condoms.

A major issue concerns inclusion. Men were evidently far less involved in FP (30% had gone to health centres for this reason, versus 75% of the women). The personal histories gathered in focus-group discussion and from some of the participants explained that these men were often not comfortable going to health centres, would feel judged by strange looks or felt that healthcare employees did not welcome them. Significantly, participants were of the opinion that FP services in the health centres are for married couples and that single people who would go to search for such services would feel judged.

FP in the DRC and in the province of South Kivu is scattered, with many different service providers related to the government, faith-based institutions and – not incorporated in this research – private clinics and pharmacies. International actors have supported the health system, but only a few have programmes related to FP – mainly in education.

A number of issues concerning FP are related to the political economy and organisation of state services. Of these, the most important are problems related to payroll issues, whereby the government fails to pay service providers who then need to make a living by monetising their services. As a result, there have been major problems, such as uneven stocking of contraceptives; while this example is partly related to logistical problems, it is certainly aggravated by service providers retaining surplus stock to sell. Another widely reported problem is that FP, which must be informed and voluntary according to government policies, can be imposed – especially when service providers are paid by the number of devices that they place. In such cases, women are offered a small present like a bra or a sack of flour, and information on side effects can be withheld. In many areas, people are not aware that FP is meant to be subsidised without user costs. There are also concerns that free provision is not sustainable.

Faith-based services are geared more towards the dignified treatment of FP, emphasising the importance of free choice and the inclusion of husbands in decision-making. Most of these organisations have a preference for natural FP methods. Religious leaders are opening up to playing a role in supporting the Provincial Ministry of Health to inform the local population about new FP methods; however, they remain firm on the aforementioned preference for natural methods.

There is a dire need to improve communication strategies, although some significant steps have been made in recent years. A new infrastructure has been established by CLOs, constituting citizens who organise community meetings or go door to door to inform the population on FP services and contraception. The system has not yet gathered much momentum, and the volunteers reported feeling that they should be rewarded in some way. Churches have a role to play in communication, although 45% of our participants had no recollection of the topic being raised in church-related events (see Table 16).

Schools are another site for communication. Education for Life and Biology – and, more recently, Sociology and Environmental Studies – are school subjects where young people are informed about sexuality and reproductive health. To enhance the church curriculum on Education for Life and increase youth knowledge on sexuality and avoiding early pregnancies and sexually transmitted diseases, CORDAID, a Dutch Catholic INGO – in cooperation with I+Solutions, Swiss TPH and the Youth Cristian Association – is pioneering projects for young people as well as joint projects with their parents and religious leaders. A major issue is that schools, the church and government all convey the message that young people should abstain from sexual activity, and take the view that informing them about FP is an open invitation for young people to engage in sex. However, this practice is slowly changing and new curricula promoted by the government and schools inform young people on healthy sexual activity.

Crucially, there is a remarkable absence of women in FP policy-making, execution and service delivery, and the vast majority of service providers consist of male nurses and other men. This may have contributed to a rather mechanical approach to FP that is geared more to targets and numbers than it is to women's reproductive rights.

8 Recommendations

- Local government and religious medical institutions should develop a strategy to inform Bukavian citizens on the role of INGOs and donors in FP services.
- Donors and INGOs should feel supported and understand that there is need for them to have a greater presence within health centres and community infrastructure.
- In South Kivu, eastern DRC, FP officials need to create a programme that is sensitive to the family typology, age, location, socio-economic status and religious beliefs of female and male family members, remaining sensitive to the existing diversity in people's experiences and ways of living.
- The unmet need for contraception is an international community and governmental strategy that needs to be translated into forms of communication that can lead to behavioural change.
- Local religious leaders have more power to be opinion leaders than provincial government and the 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.
- Since 56% of the population in South Kivu comprises young people under the age of 18, the inclusion of parents in training sessions on how to communicate SRH knowledge to their adolescent children will enable young people to become more open in communicating their fears and asking questions about their first sexual encounters in order to avoid teenage pregnancy.
- The introduction of a comprehensive SRH curriculum can enrich students' and young people's understanding of gender systems and norms in their communities. Ultimately, it can help all genders to live a youth without sexual violence, early pregnancies or sexually transmitted diseases.

References

Ackerson, K. and Zielinki, R. (2017) 'Factors influencing use of family planning in women living in crisis affected areas of Sub-Saharan Africa: a review of the literature', *Midwifery* 54: 35-60 (http://dx.doi.org/10.1016/j.midw.2017.07.021)

Ahmed, S., Li, Q., Liu, Li, M.A. and O Tsui, A. (2012) 'Maternal deaths averted by contraceptive use: an analysis of 172 countries' *Lancet* 380: 111–25

(http://dx.doi.org/10.1016/S0140-6736(12)60478-4)

Batie, S.S. (2008) 'Wicked problems and applied economics' *American Journal of Agricultural Economics* 90(5): 1176–1191 (https://doi.org/10.1111/j.1467-8276.2008.01202.x)

Black, B.O., Bouanchaud, P.A., Bignall, J.K., Simpson, E. and Gupta, M. (2014) 'Reproductive Health during Conflict' *The Obstetrician & Gynaecologist*16: 153-60

Bongaarts, J. (2014) 'The Impact of Family Planning Programs on Unmet Need and Demand for Contraception' *Studies in Family Planning* 45(2): 247–262

Bradley, S.E.K., Croft, T.N., Fishel, J.D. and Westoff, C.F (2012) 'Revising Unmet Need for Family Planning' *DHS Analytical Studies* 25: 90. USAID

Bukonda, N., N.K.Z., Chand, M., Disashi, T.G., Lumbala, C.W.B. and Mbiye, B. (2012) 'Health care entrepreneurship in the Democratic Republic of the Congo: An exploratory study' *African Journal of Business* 13(2): 1-14

Bwimana, A. (2017) 'Heath Sector Network Governance and State-building in South Kivu, Democratic Republic of Congo' *Health Policy and Planning* 32: 1476–1483 (doi: 10.1093/heapol/czx095)

Canning, D. and Schultz, P.T (2012) 'The economic consequences of reproductive health and family planning' *Series Family Planning 4, The Lancet* 380: 165-171

Carlson, C., De La Malle, J., Fustukian, S., Newell-Jones, K., Sibbons, M. and Sondorp, E. (2005) 'Improving the delivery of health and education services in difficult environments: lessons from case studies; DRC case'. DFID Health Systems Resource Centre: 1-25

Casey, S. and Tshipampa, M. (2017) 'Contraceptive availability leads to increase in use in conflict-affected Democratic Republic of the Congo: evidence from the cross-sectional cluster surveys, facility assessments, and service statistics', in *Conflict and Health*. 1-10.

Chabikuli, N. and Lukanu, P.N. (March 2007) 'Impact of contraception use among women seeking tubal ligation in the rural Democratic Republic of Congo' *SAJOG* 13(1): 1-15

Chirhamolekwa, C.F., Miatudila, M. (2014) 'Family Planning History in the DRC'. Family Planning in the DRC website (http://www.familyplanning-drc.net/historie-de-la-planification-familiale-en-rdc.php)

Chirwa, T.F., Mantempa, J.N., Kinziunga, F.L., Kandal, J.D. and Kandala, N.B. (2014) 'An exploratory spatial analysis of geographical inequality of birth intervals among young women in the Democratic Republic of Congo' *BMC Pregnancy and Childbirth* 14: 271: 1-10

Curry, D.W., Rattan, J, Jean, J. and Giri, K. (2015) 'Delivering High-Quality Family Planning in Crisis Affected Settings I: Program Implementation' *Global Health Science and Practice* 3: 14-24

Çuma Byamungu, S. *Repositioning Family Planning in South Kivu. Report.* Bukavu. June 28, 2017.

Denno, D.M., Hoopes, A.J., Chandra-Mouli, V. (2015) 'Effective Strategies to Provide Adolescent Sexual and Reproductive Health Services and to Increase Demand and Community Support' *Journal of Adolescent Health* 56: 22-41

D'Errico, N.C., Kalala, T., Nzigire, L.B., Maisha, F. and Kalisye, L.M. (2013) '"You say rape, I say hospitals. But whose voice is louder?" Health, aid and decision-making in the Democratic Republic of Congo' *Review of African Political Economy* 40(135): 51-66

DFID (2016). *DRC Evidence, Analysis and Coordination Programme (EACP). Payroll Reform in the Health Sector* (55 pages)

Dhakal, S., Song Sung, J., Shin Eun, D., Lee Ho, T., So Young, A. and Nam Woo, E. (2016) 'Unintended Pregnancy and its Correlates among Pregnant Women in the Kwango District, Democratic Republic of Congo' *Reproductive Health* 13(74): 1-7

FPWatch Group. (2016). FPWatch Study Reference Document: The Democratic Republic of Congo 2015. Washington DC: USA. Retreived from http://www.familyplanning-drc.net/documentation-sur-la-rdc-rapports.php in November 2018.

Freedman, J. (2015) 'Gender Relations in Pre-and post-colonial Congo' *Gender, Violence and Politics in the Democratic Republic of Congo* 19–39

Gruda, A. (2007) *Albanian middle-class working mothers: formal and informal practices of child-rearing* (Ma thesis, Utrecht University, 120)

Haider, H., Mcloughlin, C. and Scott, Z. *Topic Guide on Communication and Governance*. Produced in collaboration with the Communication for Governance and Accountability Program. August 2011.

Head, B.W. (2008) 'Wicked Problems in Public Policy' [online] *Public Policy* 3(2): 101–118 (https://search.informit.com.au/documentSummary;dn=662880306504754;res=IELFSC> ISSN: 1833-2110)

Hernandez, J.H., Mbadu, M.F., Garcia, M. and Glover, A. (2018) 'The provision of emergency contraception in Kinshasa's private sector pharmacies: experiences of mystery clients' *Contraception* 97: 57–61 (http://dx.doi.org/10.1016/j.contraception.2017.08.001)

Hickey, S., Sen, K. and Bukenya, B. (2015) 'Exploring the Politics of Inclusive Development: Towards a New Conceptual Approach' *The Politics of Inclusive Development: Interrogating the Evidence*. Oxford, Oxford University Press

Hilhorst, D. and Bashwira, M. (2014) 'The Women`s Movement in South Kivu, DRC: A civil society analysis' Occasional Paper #11, Special Chair Humanitarian Aid and Reconstruction (62 pages). Wageningen University

Hilhorst, D. and Douma, N. (2017) 'Beyond the hype? Responses to sexual violence in DRC in 2011 and 2014' in D. Hilhorst, H. Porter and R. Gordon (eds.) *Special issue on Gender, sexuality and violence in humanitarian crises*, *Disasters* 41(S1): 79–98 (https://onlinelibrary.wiley.com/doi/abs/10.1111/disa.12270)

Hilhorst, D. and Jansen, B.J. (2010) 'Humanitarian Space as Arena: A Perspective on the Everyday Politics of Aid' *Development and Change* 41(6): 1137–1139 (https://doi.org/10.1111/j.1467-7660.2010.01673.x)

Isumbisho, M., Hilhorst, D., Mashanda, M., Bahananga, M. and Mugenzi, R. (2016) 'Women engaging in transactional sex and working in prostitution: Practices and underlying factors of the sex trade in South Kivu, the Democratic Republic of Congo'. London: Secure Livelihoods Research Consortium (http://securelivelihoods.org/publications_details.aspx?resourceid=394)

Kayembe, P., Babazadeh S., Dikamba N., Akilimali P., Hernandez J. and Binanga A. (2015) ,Family planning supply environment in Kinshasa, DRC: survey findings and their value in advancing family planning programming' *Global Health, Science and Practice* 3(4): 630-645 (http://dx.doi.org/10.9745/GHSP-D-15-00298)

Kabeer, N. (1994), 'Implementing the Right to Choose: Women, Motherhood and Population Policy', in *Reversed Realities. Gender Hierarchies in Development Thought*. Verso. London, New York. Pp. 187-222

Kidman, R., Palermo, T. and Bertrand, J. 'Intimate partner violence, contraceptive use and conflict in the Democratic Republic of Congo' *Social Science and Medicine* 133: 2–10 (http://dx.doi.org/10.1016/j.socscimed.2015.03.034)

Kisindja, RM., Kimona C., Etoy, M., Dorme, F. and Benfield, N. (2017) 'Family planning knowledge and use among women in camps for internally displaced people in the Democratic Republic of the Congo', in *International Journal Gynecology Obstetrics*. Volume 138, Issue 3. 256-260

Knorr, M. (2016) *Promoting Gender Equality within Family Planning Programs: An Analysis of USAID Projects* (Master's thesis, University of Pittsburgh)

Kyamusugulwa, P.M., Hilhorst, D. and Bergh, S. (2018) *The importance of gender norms in promoting social accountability for women in the South-Kivu province in the Democratic Republic of Congo*. SLRC Research brief. London: ODI (1–14)

Kwete, D., Binanga, A., Mukaba, T., Nemuandjare, T., Mbadu, M.F., Kyungu, MM., Sutton, P. and Bertrand, J.T. (2018) 'Family Planning in the Democratic Republic of Congo: Encouraging Momentum, Formidable Challenges' *Global Health: Science and Practice* 6(1): 40–54)

Longwe, A. and Smits, J. (2012) 'Family Planning Outcomes and Primary school attendance in Sub-Saharan Africa' *Studies in Family Planning* 43(2): 127–134

McGinn, T. (2000) 'Reproductive Health of War Affected Population: What do we know? *International Family Planning Perspective* 26(4): 174–180

Moshonas, S. (2014) 'The politics of civil service reform in the Democratic Republic of Congo' *The Journal of Modern African Studies* 52: 251–276

Mpunga, D. Lumbayi, J.P., Dikamba, N., Mwembo, A., Mapatano, M.A. and Wembodinga, G. (2017) 'Availability and quality of Family Planning Services in the Democratic Republic of Congo' *Global Health: Science and Practice* 2017 5(2): 274–285

Muanda M., Ndongo, P.G., Taub, L.D. and Bertrand, J.T. (2016) 'Barriers to Modern Contraceptive Use in Kinshasa, DRC' *PLoS ONE* 11(12): 1–13 (DOI:10.1371/journal.pone.0167560)

Mugisho, A. (2016) *Landscaping analysis. Female condoms in the Democratic Republic of Congo: Policies and Stakeholders*. Oxfam Novib, the Hague. (1–30)

Mukaba, T., Binanga, A., Fohl, S., Bertrand J.T. 'Family Planning Policy Environment in the Democratic Republic of Congo: Levers of Positive Change and Prospects for Sustainability' *Global Health: Science & Practice* 3(2): 163–173 (http://dx.doi.org/ 10.9745/GHSP-D-14-00244)

Mulumeoderhwa, M. (2016) 'A girl who gets pregnant or spend the night with a man is no longer a girl': Forced marriage in the Eastern Democratic Republic of Congo' *Sexuality & Culture* 20: 1042–1062 (DOI: 10.1007/s12119-016-9373-y)

Newbrander, W., Waldman R. and Shepherd-Banigan, M. (2011) 'Rebuilding and strengthening health systems and providing basic health services in fragile states'. *Disasters*, 35: 4, 639-660

Nguya, G. (2016) *Brining Internally Displaced Persons back into sight into Democratic Republic of Congo.* Briefing Paper. Researching Livelihoods and services affected by conflict. (4 pages) London: SLRC.

Ntambue, A., Malonga Kaj, F., Dramaix-Wilmet, M. and Donnen, P. (2012) 'Determinants of maternal health services in Urban settings of the Democratic Republic of Congo – A case study of Lubumbashi city' *BMC Pregnancy and Childbirth* 12(66): 1–13

Paluku, L.J., Mabuza, L.H., Maduna, P.M.H., and Ndimande, J.V. (2010) 'Knowledge and attitude of school girls about illegal abortions in Goma, Democratic Republic of Congo. *African Journal of Primary Health Care and Family Medicine* 2(1): 1–5

Patel, P., Dahab, M., Tanabe, M., Murphy, A., Ettema, L., Guy, S., and Roberts, B. (2016) 'Tracking official development assistance for Reproductive Health in Conflict Affected Countries' *BJOG an International Journal of Obstetrics and Gynaecology* 1693–1704

Pavignani, E., Michael, M., Murru, M., Beesley, M. E. and Hill, P. S. (2013) 'Making sense of apparent chaos: health-care provision in six country case studies' *International Review of the Red Cross* 95(889):41–60

Pearson, N. (2011) *Case Study: Democratic Republic of the Congo.* DFID, Practical Action Consulting, Save the Children, and CfBT Education Trust, Kinshasa

Petchesky, Rosalind, P. (1986). *Abortion and Woman's Choice. The State, Sexuality and Reproductive Freedom.* Great Britain, Verso.

Petchesky, Rosalind, P. (2000). *Reproductive and Sexual Rights: Charting the Course of Transnational Women NGOs* (72 pages). United Nations Research Institute for Social Development (UNRISD), Geneva

Ratnayake, R., Degomme, O., Roberts, B. and Spiegel, P. (2014) 'Conflict and Health: seven years of advancing science in humanitarian crisis' *Conflict and Health* 8(7): 2–6

Romaniuk, A. (2011) 'Persistence of High Fertility in Tropical Africa: The Case of the Democratic Republic in Congo' *Population and Development Review* 37(1): 1–28

Sedgh, G., Singh, S., Shah, I.H., Åhman, E., Henshaw, S. K. and Bankole, A. (2012) 'Induced abortion: incidents and trends worldwide from 1994 to 2008' *The Lancet*, 379(9816): 625–632

Senanayake, P. (1999) 'Family planning perspectives at the beginning of the next century, The European Journal of Contraception & Reproductive Health Care' 4:4: 202–211 (DOI: 10.3109/13625189909071340)

Sturge, G., Mallett, R., Hagen-Zanker, J. and Slater, R. (2017) *Tracking livelihoods, services and governance: panel survey findings from the Secure Livelihoods Research Consortium*. London: SLRC (https://securelivelihoods.org/wp-content/uploads/Tracking-livelihoods-service-delivery-and-governance_Panel-survey-findings-from-the-Secure-Livelihoods-Research-Consortium.pdf)

Shapiro, D. (2015) 'Enduring economic hardship, women's education, marriage and fertility transition in Kinshasa' *Journal of Biosocial Science* 47: 258–274 (DOI:10.1017/S0021932014000091)

Shapiro, D. (1996) 'Fertility Decline in Kinshasa' *Population Studies* 50(1): 89–103 (http://www.jstor.org/stable/2175032)

Titeca, K. and De Herdt, T. (2011) 'Real Governance Beyond the 'Failed State': Negotiating Education in the Democratic Republic of Congo *African Affairs* 110/439: 213–231 (published by Oxford University Press on behalf of Royal African Society: DOI: 10.1093/afraf/adr005)

Thontwa, S., De Herdt, T, Marivoet, W. and John Ulimwengu, J. (2017) National Datasets on Livelihoods in the DRC: Precisely Wrong or Vaguely Right? IOB Working Paper, no. 12. https://www.uantwerpen.be/en/research-groups/iob/publications/working-papers/wp-2017/wp-201712/

Tunçalp, Ö., Fall, I.S., Phillips, S.J., Williams, II., Sacko, M., Boubacar Touré, O., Thomas, L.J. and Say, L. (2015) 'Conflict, displacement and sexual and reproductive health services in Mali: analysis of 2013 health resources availability mapping system (HeRAMS) survey' *Conflict and Health* 9(28): 1–9 (DOI: 10.1186/s13031-015-0051-8)

UNHCR (1999) *Reproductive Health in Refugee Situations. An Inter-Agency Field Manual*. https://www.unhcr.org/403a0f6c8.pdf

Verweijen, J. and Wakenge, I.C. (2015). *Understanding Armed Group Proliferation in the Eastern Congo.* RIFT Valley Institute PSRP. Briefing Paper 7.

Vila-Torres, L. & Svanemyr, T. (2015). *Ensuring youth's right to participation and promotion of youth leadership in the development of sexual and reproductive health policies and programs*. The Journal of Adolescent Health. 56 (1): 551-557 (DOI:10.1016/j.jadohealth.2014.07.022)

Vlassenroot, K. and Romkema, H. (2007) *Local Governance and Leadership in Eastern DRC*. Research commissioned by Oxfam-Novib.

Weijs, B., Hilhorst, D. and Ferf, A. (2012) *Livelihoods, basic services and social protection in Democratic Republic of the Congo*. Working Paper 2. Wageningen and London: Wageningen University and SLRC

World Bank. (2005) *Democratic Republic of Congo: Health, Nutrition and Population. Country Status Report'* (1–98). Report 35626-ZR. Washington D.C.: African Region Human Development and the Ministry of Health, Democratic Republic of Congo, World Bank

World Bank. (2007) *Democratic Republic of Congo. Reforming the Public Service Wage System*. Background Paper. Report No. 42514-ZR. Washington D.C.: Public Sector Reform and Capacity Building Unit (AFTPR), Africa Region. World Bank (1–54)

Annex 1

List of institutions and their representatives met and interviewed for this research

Meetings and qualitative interviews were conducted with: Provincial Ministry of Health; Provincial Division of Sexual and Reproductive Health (PDSRH); Provincial Ministry of Education, pharmacist and administration officer of the Ibanda health zone, Diocesan Office for Medical Service; Protestant Office for Medical Services; Coordination Institute of Catholic Schools at the Catholic Diocese Bukavu; civil society and catholic trainers of the Bukavu Diocese on SRH and FP; Dutch Catholic Organisation on Relief and Development Aid (CORDAID), German Cooperation (GIZ); Swiss Cooperation; I+Solutions[1]; Swiss TPH; UNFPA-Bukavu; International Rescue Committee-Bukavu; International Committee of the Red Cross-Bukavu; Medicines Sans Frontiers Bukavu, International Organization for Migration (IOM) Bukavu; and Association for Family Planning.

From the CSO, there were interviews conducted with: the Coordinator of Justice for All – Coordination Office at the Civil Society in South Kivu; SOFEDI; Synergy for Congolese Women Association; Socio-Economic Action for Marginalised Women; and Youth World Council Association.

Representatives of governmental institutions

1. Meeting with the Head of the Population and Civil Status Office/International Foreign Police (Chef de Bureau Population et Etat Civil/Changé de la Police International Etrangers).
2. Interview with the Director of the Programme National de la Sante de la Reproduction and the Chair of the Department of Provincial Division on Sexual and Reproductive Health in South Kivu, Provincial ministry of Health.
3. Interview with the Adviser of the Provincial Minister of Education.
4. Interview and meeting with Dr. Socrates Çuma, Assistant Technique of the Department of Provincial Division on Sexual and Reproductive Health in South Kivu, Provincial ministry of Health.
5. Interview with the Director and assistant technique of the National Programme on HIV for the province of South Kivu.

Representatives of the religious institutions

1. Interview with an anonymous sister from the Catholic Community.
2. Interview with and anonymous male Religious leader of the Catholic Parish in Nguba neighborhood.
3. Interview for the Family Planning section, Bureau de coordination de Project Protestant (BYCOP).
4. Interview with the former Leader of the BDOM.
5. Interview with the Responsible Person for the Family Planning Programme at BDOM.
6. Interview with the Director of the Association of Protestant Women.
7. Interview with the Educational Councillor at the Coordination of Catholic Schools in Bukavu.
8. Interview with the Religious Protestant Leader in Kadutu Commune.

Representatives of the international organisations

1. Meeting and interview with the Senior Programme Manager of Women for Women International in Bukavu.
2. Meeting with the Coordinator Provincial Ituri Nord and South Kivu and the Coordinator of the JS3 Project, CORDAID.
3. Interview with the Coordinator of the JS3 Project, CORDAID.
4. Interview with the representative of IOM.
5. Meeting and interview with the programme manager of UN Women for South-Kivu.

1 I + solution is a Dutch organisation that 'provides services that support the procurement and distribution of essential medicines, supporting governments and organizations in their quest for creating sustainable access to medicines and health products' (http://www.iplussolutions.org/about-us).

6 Interview with the Chef D`equipe, responsible for the Health Program, SRH and FP included.
7 Interview with the responsible for Sexual Violence Program, Swiss Cooperation.
8 Interview with the person in charge of the UNFPA programme in South-Kivu.
9 Interview with the country representative at I+Solutions for the DRC.
10 Interview with the Supervisor for Reproduction Health in Kalehe, International Rescue Committee.
11 Interview with the Responsible for the Health Programme at Swiss Cooperation.
12 Interview with the responsible person for the Health Programme at Cordaid.

Representatives of the CSOs

1 Meeting with the Coordinator of Justice Pour Tous and Rapporteur au Bureau de Coordination de la Société Civile du Sud Kivu.
2 Interview with the president of SOFEDI
3 Interview with representatives of Action Socio-economique en faveur des Femmes Marginalisee.
4 Interview with the President of Sunergy for Congolese women.
5 Interview with the former Director of the Association for Family Planning.

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