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SOCIAL CHANGE AND FAMILY PLANNING

**Linking Social Norms to Family Planning Behaviors:
Baseline Survey for the Results Initiative**



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BACKGROUND

Begun in 2008, the Social Change for Family Planning Results Initiative (RI) is a four-year CARE effort to improve the use of family planning, sustain health improvements and improve community capacity to address inequities. To accomplish these goals, the initiative is addressing social norms and cultural factors that influence family planning access and use. The RI currently targets women and men of reproductive age in resource-poor areas of three countries: Ethiopia, Kenya and Rwanda. Technical assistance for the project is provided by CARE's Sexual and Reproductive Health team; research assistance is provided by Dr. Rob Stephenson at Emory University's Rollins School of Public Health.

In each country, the initiative is designed to be embedded within one or two anchor projects. This allows CARE to experiment with a program-style approach that promotes synergy in the allocation of common material and human resources while building on and enhancing relationships with communities and stakeholders, institutions, and formal and informal networks. The programmatic approach of the RI also allows for the development of crosscutting approaches to address social and gender inequity and improving impact.

The cornerstone of this multi-country initiative is the further development and refinement of the Social Analysis and Action¹ (SAA) approach to exploring and facilitating change. An SAA lens to programming adds iterative and reflective elements to the traditional program action cycle that helps identify and address underlying social and cultural factors that influence family planning behaviors within a community. The initiative also uses a Family Planning Results Framework (see appendix) to define a theory of change, the intervention, and indicators for measuring change. From this framework, the initiative identified several intermediate results covering both health and social domains:

1. Increased family planning knowledge and demand.
2. Increased access to and quality of family planning health services.
3. Increased gender equity at the household level.
4. Increased equity in social norms and action at the community level.

METHODOLOGY

Comprehensive baseline instruments were designed using a combination of quantitative and qualitative tools to measure fertility and family planning behavior, along with the range of social, cultural, economic and attitudinal factors thought to influence such behavior. A central theme in the research was learning how a range of social and gender norms, attitudes and behaviors at both the household and community level influence family planning behavior among men and women.

The baseline survey took place in all target areas in January and February 2009. Quantitative and qualitative data were collected using the same tools in all study settings, allowing for comparisons across the three countries. By controlling for confounding variables such as economic and education status, the link between social and health behavior factors can also be established. The research design was approved by the Emory University Internal Review Board and verbal consent was obtained from all respondents.

The data collection process included a quantitative household survey and three qualitative tools:

Quantitative Household Survey

The household survey randomly selected 600 women and 300 men in each country using stratified sampling. Each respondent was married and between the ages of 18–45. Only one respondent

(man or woman) was interviewed per household. The quantitative survey questionnaire was adapted from the Demographic and Health Survey. In addition, a 26-item scale was developed based on the Gender Equitable Men (GEM) scale² and the Sexual Relationship and Power (SRPS) scale³ to measure attitudes toward gender roles and expectations as well as relationship power factors, including decision-making. A health facility assessment was also conducted for the areas surveyed (when feasible) to determine quality and availability of family planning services.

Qualitative Data Collection Tools

Three different tools were used to collect information from voluntary respondents in 2–3 purposively selected communities in each country.

1. Focus group discussions were held in several communities in each country, targeting groups of men, women and elders. A few key informant interviews were also conducted using a similar question guide.
2. Pile sorting and ranking discussions: Groups of men and women were asked to categorize and rank lists of household tasks, decision-making responsibilities, and men's and women's characteristics, according to whether they pertained to men, women or both.
3. Social mapping: Groups of men and women were asked to map their communities, identifying the availability of information and services around family planning and the factors that enhance or inhibit its use.



Findings

The project tools and indicators worked well in all three countries; they were flexible enough to adjust to specific country settings and needs. Country-specific findings for the baseline survey are included in a baseline report for each country (see appendix). The following outline highlights some of the interesting quantitative and qualitative findings:

QUANTITATIVE RESULTS

(Family Planning and Fertility)

- Respondents reported high rates of approval (80–98%) for family planning use for married couples in general, but not for adolescents (Ethiopia) nor newly married couples (all).
- There still appears to be an unmet need for family planning. About one-third of respondents in all three countries reported that their last pregnancy was unplanned.
- Ideal family size is still high. In Ethiopia, many respondents reported interest in having more than seven children.
- High approval for family planning was associated with respondents' reports that they believed that their friends and spouse approve of family planning.

QUANTITATIVE RESULTS

(Gender and Power)

- When scored as a continuous variable, gender equity scores ranged in a bell-curve pattern among all six respondent groups, from very equitable to very traditional.
- When adjusted for other social variables (e.g., education and economic status, age when married), male and female respondents in Ethiopia and Kenya

with “high” gender equity scores were positively associated with family planning use compared with those scoring “medium” or “low.”

- Also in Ethiopia and Kenya: When adjusted for other social variables (e.g., education and economic status, age when married), men's responses of “high” power over their respective spouses were associated with family planning use, but women's responses of “high” power were not.

QUALITATIVE RESULTS

While the qualitative results are complex and varied, they suggest that social norms around fertility, gender, family size and family planning use may be more conservative than individual attitudes would suggest. Other observations include:

- Respondents cited economic needs and lack of land as reasons for family planning but otherwise say large families are better for social and historical reasons.
- Fear of spousal abandonment motivates women to comply with traditional gender roles and husbands' family planning preferences.
- There is disagreement on whether unmarried girls' having access to family planning is acceptable, recognizing that unwanted pregnancy is also a problem.
- Data show differences in how men and women express their gender attitudes and concerns. Both tended to agree on responsibilities for household chores, but women tended to report that they are more involved with family decision-making than men think they are.

The baseline survey also indicated that the RI approach of working within an anchor project and using the Social Analysis and Action (SAA) approach has led to increased cross-sectoral learning and collaboration.

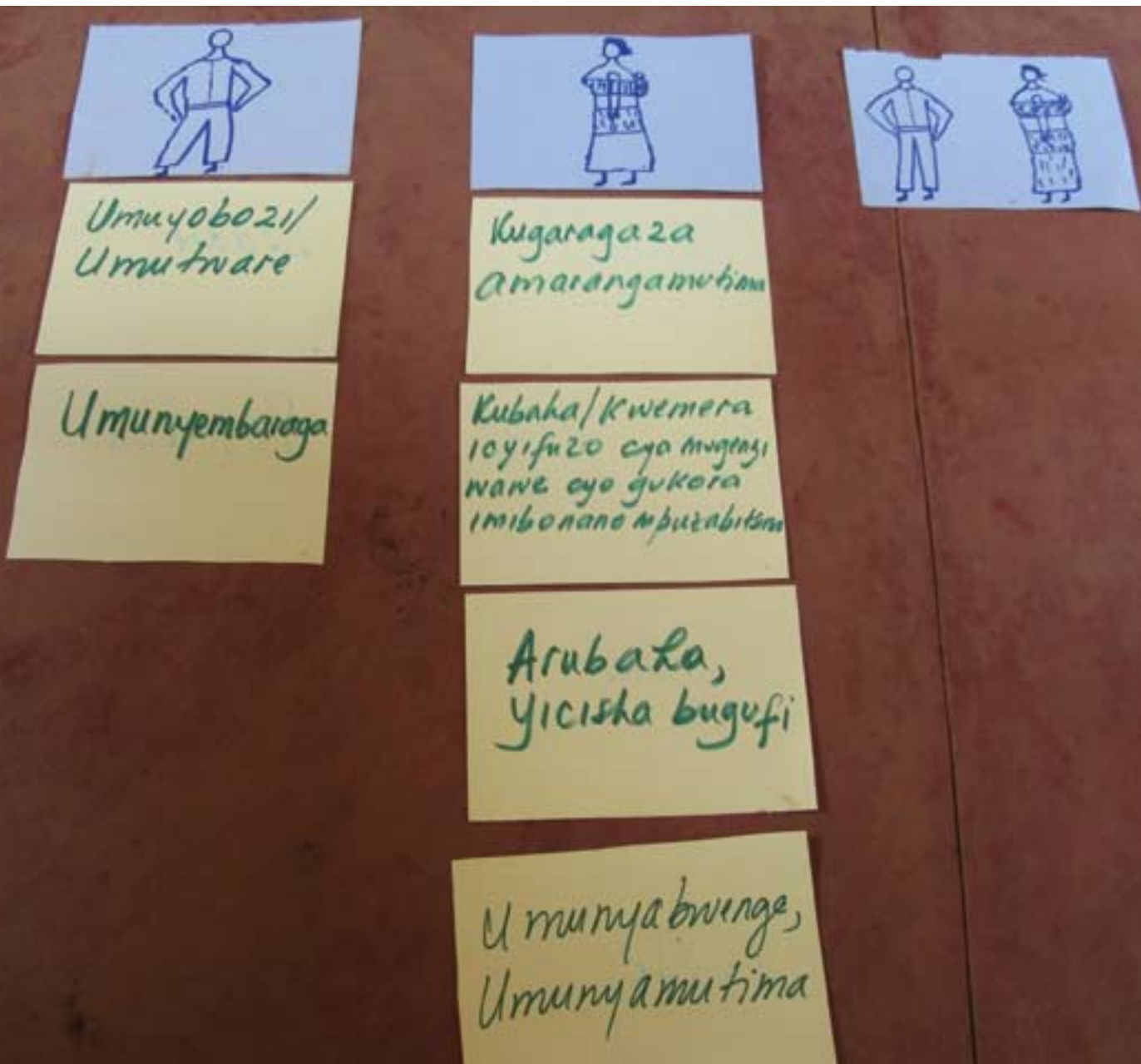
The RIs are also contributing to concurrent country office strategies for coherent systemic approaches to development work.

DISCUSSION

The baseline survey confirmed significant links between gender attitudes, relationship power, social norms and family planning behaviors. As a result, the RI country projects have developed strategies to address and challenge these attitudes and norms, with the hope that family planning use will also improve.

Recognizing that changes in gender and social norms and attitudes may require approaches other than direct behavior-change strategies that focus on specific knowledge and practices, the RIs are developing activities that are designed to catalyze candid and sometimes contentious discussions on the broader implications of personal beliefs, attitudes, health and well being. Examples include participatory theater, community dialogues, couples communication, and reflective practice. These strategies emphasize the importance of ongoing exploration and reflection to continue identifying deeply entrenched social factors that influence norms and attitudes around gender

Pile sorting exercise categorizing household and decision-making roles and responsibilities.



and fertility. These activities identify entry points for challenging these norms with different community groups and at various social levels, including with peer support groups, couples, and service providers.

Looking Forward

The success of the baseline survey was due in part to excellent teamwork, preparations and strong commitment from country office staff and senior leadership. Developing, conducting and reflecting on the baseline survey was an important step for this initiative. The three country

programs are using this data to inform and improve their strategies to create greater recognition of the importance of social determinants of health. As the RI concludes its second year of programming, country office teams are further rolling out implementation into the community and health facilities, while monitoring service-utilization data. As a learning initiative, the RI country office teams are also learning and sharing across RI country initiatives and other social change and family planning projects supported by CARE USA. In 2010, the RIs have scheduled a midterm review to assess learning and results to date and develop a strategy for the next two years of programming.



The Reproductive Health Trust Fund (RHTF) is a cooperative agreement supported by investments from the United States Agency for International Development (USAID) and CARE private donors. The RHTF was designed to support the institutionalization of sexual and reproductive health programming within CARE and a core capacity to implement family planning and other SRH programs worldwide. The RHTF supports the Social Change for Family Planning Results Initiative.

APPENDIX

Baseline Reports

Social Change for Family Planning Results Initiative in Kenya, Rwanda, and Ethiopia Baseline Results 2009.

This report details results from baseline data collection for Social Change for Family Planning Results Initiative in Ethiopia, Kenya and Rwanda. Data were collected in January and February 2009, with the aim of providing baseline measures of fertility and family planning behaviors as well as the range of social, cultural, economic and attitudinal factors thought to influence such behaviors. Developed by Rob Stephenson, PhD. Available from Luis Ortiz (lortiz@care.org).

Baseline Reports for CARE Ethiopia, CARE International in Kenya, and CARE Rwanda (2009).

Each of these country-specific reports describes the process and outputs of a qualitative and quantitative baseline survey conducted in early 2009. Available from Luis Ortiz (lortiz@care.org).

Tools and Resources

Family Planning Results Framework with Social Change Component

In this diagram, the black text represents a traditional model for increasing family-planning use. The orange text represents components that also address gender equity and social change. Available at <http://tinyurl.com/2bgbu3d>.

Ideas and Action: Addressing the Social Factors that Influence Sexual and Reproductive Health (CARE, 2007).

This manual describes how CARE staff and partners used the Social Analysis and Action (SAA) approach to identify and address the social, economic and cultural factors that influence reproductive health. Available at www.care.org/reprohealth.

CARE SRH Listserv

This listserv aims to increase CARE staff and partner access to state-of-the-art SRH information and to encourage SRH networking and knowledge sharing. Available at <http://groups.google.com/group/care-srh-listserv>.

END NOTES

- ¹ Ideas and Action: Addressing the Social Factors that Influence Sexual and Reproductive Health. CARE, 2007.
- ² Pulerwitz, J and Barker, Gary. 2008. Measuring Attitudes Towards Gender Norms among Young Men in Brazil: Development and Psychometric Evaluation of GEM Scale. *Men and Masculinities*, 10 (3), 322 – 338.
- ³ Pulerwitz, J, Gortmaker, SL, & DeJong, W. 2000. Measuring Relationship Power in HIV/STD Research. *Sex Roles*. Vol. 42, Nos. 7/8.

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