Project Update: The Family Planning Results Initiative: Addressing the Social Factors that Influence Family Planning

Background

The goal of the four year Family Planning Results Initiative in Rwanda, Kenya and Ethiopia is to increase and sustain the use of family planning by both improving the quality and availability of family planning information and services and addressing the underlying social and cultural barriers to family planning, including gender norms.

Results Initiative Timeline

2008
Situational Analysis
Project Launch
Implementation Plans

2009
Qualitative + Quantitative Baseline

2010
Midterm Review

2013
Final Qualitative + Quantitative Evaluation

Ways of Working

Learning together: The Results Initiative is designed as a learning partnership between CARE USA and CARE Ethiopia, CARE Rwanda and CARE Kenya. Together, we are exploring and documenting strategies for increasing acceptance and utilization of family planning and other sexual, reproductive and maternal health services. We are prioritizing the development of strategies for empowering communities to address social and cultural barriers to family planning, including restrictive gender roles, inequitable power relations in the household and harmful traditional norms and practices like son preference. We collaborate through technical workshops that bring together RI project teams from all countries, through visits from CARE USA to each RI country, and ongoing learning and exchange among all RI partners through an online community of practice.

Program Integration: The RI was not designed as a stand-alone initiative; through the RI, CARE USA provided small grants and strategic infusions of technical support to enable RI countries to integrate family planning activities into existing CARE projects (such as a CDC-funded PMTCT project in Kenya.) Since the inception of the RI, the CARE "anchor projects" in Ethiopia and Kenya have ended, and now these countries are integrating RI activities into existing community groups, health systems and education systems- which might help ensure sustainability and also help build local ownership and capacity. In Rwanda, where the RI is being integrated into CARE-supported VSLA groups, we are exploring VSLA as a platform for integrated programming.

The RI in Rwanda is intended to develop and test a model for integrating FP and women's empowerment programming into VSLA. The activities of the two initiatives - RI and *SAFI* VSLA- are intended to work synergistically to ensure that the objectives of both projects are met. RI Peer educators working in VSLA groups facilitate reflection and discussion to identify and challenge restrictive gender roles and inequitable power dynamics in households. Addressing gender dynamics helps to ensure women's meaningful participation in VSLA, as well as helping ensure that women can negotiate for and access family planning services. VSLA groups provide a critical platform for convening women and couples to have these discussions as well as to share family planning information and linkages to services. Essentially, the SAFI-RI integration is designed to contribute to a range of empowerment outcomes for women including achieving social and economic empowerment as well as better sexual and reproductive health.

Core elements of the RI:

The RI programs work with local partners to help strengthen health care systems to improve family planning information and services, and to engage communities to identify and address barriers to family planning. The "partner mix" differs from country to country, but each RI project uses the same core strategies:

- **Partnerships with health authorities to improve availability and quality of FP services.**
  - Refurbishing family planning clinics
  - Training clinic- and community-based health providers in family planning counseling and method provision
  - Coordination with health authorities and other partners to help ensure reliable supply of FP commodities
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- **Partnerships with local leaders and community groups to address social and cultural barriers to FP/SRMH, including gender norms.**
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  - Providing training/ongoing support to peer educators and community health care workers so that they can initiate and sustain critical dialogue with communities about gender roles, sexuality and family planning
    - Peer educators lead community-wide dialogues, such as *barazzas* (traditional community meetings in Kenya)
    - They also facilitate ongoing dialogue with small groups over time - including VSLA, PLHIV support groups, couples groups (including newly married couples)
    - The project is also using some SBCC approaches including community theatre (Kenya) and a radio serial drama (Ethiopia)

  - Partnering with local leaders who act as champions and role models for family planning and equitable gender roles in their communities.

    - In Kenya, local government administrators formed a "couples" group with their own partners, met regularly to discuss FP, sexuality and gender, and then spoke out publicly about their own experiences with change (adopting family planning, and negotiating new roles in their couples)
    - In Rwanda, the team engaged with religious leaders, some of whom initiated discussion about FP and gender within their congregations and in their counseling with couples

Results/outcomes to date

On-going analysis of FP utilization data from health posts/clinics confirms an increase in uptake/use of FP during the life of the project. In Siaya District, Kenya, current use of family planning by women of reproductive age (18-49) increased from 18% in 2008 to 56% in 2011. (Siaya District Development Plan Reports, 2008-2011 and 2011-2016).

Focus group discussions from a mid-term program review conducted in fall of 2010 helped identified other key changes to date and provided insight into how RI program strategies were contributing to changes. These intermediate outcomes and causal pathways will be systematically measured in the endline evaluation.

Key findings:

- Participants reported changes in gender dynamics at the household, including

    - More communication among couples, including about sexuality and family planning – including women asking for sex, or being able to refuse sex
    - More shared decision-making, including around household duties and finances, family planning
    - Negotiating and experimenting with more equitable division of household chores, including childcare
    - An interesting finding is that both men and women reported- and highly valued- "affective changes" in their couples that they associated with improved communication and more shared decision-making including "more harmonious" households, feelings of "more love and caring" in couples. This is an important finding: these affective changes could be an important motivator for sustaining better communication and more equitable gender roles.
    - It is also important to note that men reported fear of ridicule from community members, if they engaged in non-normative gender behaviors - i.e. shared household decision-making and tasks with women (some men talked about "hiding" the changes in their households.)

- Some participants reported changes in health behaviors, including:
    - More couples seeking family planning and VCT services together (including women who had previously "hidden" use of FP from their partners)
    - More disclosure of HIV status to partners
    - More individuals seeking FP services

- Social support and social capital generated through community groups helps enable change
    - Participants in community groups that met regularly for ongoing dialogue and discussion (e.g. women's support groups, VSLA groups, PLHIV support groups, PMTCT support groups) build a strong sense of trust and solidarity – this social support was highly valued and groups provided a safe and supportive environment to:
        - Discuss how cultural norms and practices (like son preference) adversely affected the health and well-being of themselves/their communities
        - Question/challenge these norms and discuss alternatives
        - In some groups, participants experimented with new attitudes and behaviors (such as initiating discussions about sexuality with partners) and reported back to the groups about success/challenges
        - For very marginalized people- such as widowed and divorced women in Ethiopia- these groups helped create social support and social cohesion, helped increase self-confidence and self-efficacy to participate in public life as well as to

seek sexual and reproductive health services. Collectively, women in these groups engaged with community leaders to challenge some of the stigmatizing attitudes and discriminatory treatment that limited their life choices, including the use of family planning services.

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