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Identifying social norms that impact men's ability to discuss family planning in the Democratic Republic of the Congo

Application of the Social Norms Exploration Toolkit (SNET)

Final Report

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Acronymes

BA-RDC	Breakthrough ACTION RDC
DHS	Demographic and Health Survey
DPS	Département provincial de santé (Provincial health department)
DRC	Democratic Republic of the Congo
FP	Family Planning
IRH	Institute for Reproductive Health at Georgetown University
PNSR	Programme National pour la Santé Reproductive (National Program for Reproductive Health)
ReCo	Relais communautaire (Community health worker)
SBC	Social and behavior change
SNET	Social Norms Exploration Toolkit
USAID	United States Agency for International Development
USAID-IHP	USAID Integrated Health Project

Executive Summary

Background

The Democratic Republic of the Congo (DRC) is proceeding slowly through the demographic transition. Further progress in promotion of family planning in DRC depends on improving quality of services and contraceptive supply and increasing demand for family planning among couples and building support from communities. Men's lack of communication around family planning (FP) may contribute to the social norms that discourage adoption of family planning. These include perceptions that husbands and other family and community members do not support their use of FP, and that there is pressure from family and community members to have more children. This study further unpacks these social-normative influences and identifies others that could improve men's ability to have informed and positive conversations with influential family and community members as well as their partners.

Social norms are unwritten rules of behavior shared by members of a given group or community. They dictate what people in a community believe is typical (normal) and appropriate (approved) behavior. Social norms can impact health directly or indirectly, perpetuate harmful practices or reinforce gender or other inequalities. The Social Norms Exploration Guide and Toolkit (SNET) was developed by the USAID-funded Passages Project and the Institute for Reproductive Health at Georgetown University. The SNET is divided into five overarching steps, including (1) a planning period, which in this application included a root cause analysis or "problem tree" exploring barriers to male engagement in family planning discussions with members of the Breakthrough ACTION-DRC program team, and development of the research protocol, (2) identification of reference groups, (3) exploration of social norms through selected activities conducted during semi-structured interviews and focus group discussions, (4) analysis of results, and (5) application of findings.

Objectives

The Social Norms Exploration Toolkit (SNET) has been piloted within communities with differing religious backgrounds in Kinshasa (https://irh.org/projects/passages/). This study sought to apply the SNET in smaller cities and rural areas far from the capital. The study had the two research aims:

Pilot test and further validate the SNET toolkit in urban and rural sites in the Democratic Republic of the Congo (DRC).

Provide data on gender roles and social norms with respect to family planning, to inform the development of social and behavior change interventions to be implemented in the DRC.

This report presents 1) the experience of applying the SNET in the context of the DRC, 2) findings from a participatory qualitative data analysis of the interview and focus group discussion transcripts, and 3) recommendations for future behavior change communication on family planning in DRC, informed by data on normative influences.

Methods

The study was fielded in three provinces, including one health sub-district from each of two urban and two rural health zones in each province. Data collection took place in three distinct phases. The **first phase** used a rapid, tablet-based questionnaire to identify the people in the community with whom men stated they were most comfortable discussing family planning. From these data, reference groups were constructed for each of the geographic areas (urban and rural) in the different provinces.

The **second phase** consisted of semi-structured interviews with a subsample of six married and two unmarried men per province who had participated in the rapid questionnaires. Interview participants were asked a series of open-ended questions pertaining to their experiences with family planning, their involvement in the family-planning process, and their perception of the male role in this process.

The third phase took place several days after the first two phases, allowing the data collectors time to analyze the questionnaire results from Phase 1 and recruit participants fitting the reference group criteria to fo-

cus groups. Four focus groups were held in each of two health zones per province, one urban and one rural, with two different types of reference groups.

Results

Phase 1: Reference group questionnaires - A total of 317 men were recruited and asked to identify with whom they felt most comfortable discussing family planning. The most cited group across all provinces was healthcare providers at 47%. In urban areas, there was a preference to talk to doctors (47%), as opposed to nurses in rural areas (66%). The second most cited group was friends or peers (24%) followed by family members (20.2%). Some differences were observed by province, with respondents in Lualaba most frequently citing friends rather than providers, and those in Kasai Central citing family members (and their wives in particular) more often than friends. Among those who cited talking to or being comfortable talking to family members, participants in Kasai Central and Lualaba said they were most likely to talk to their partners, at 50% and 54% respectively.

Phase 2 and 3: Qualitative analysis of transcripts from semi-structured interviews and focus group discussions.

The behavior of interest was men's involvement in birth spacing. Norms guiding whether and with whom men can discuss family planning affect their ability to talk about FP with other members of their community, in turn influencing their attitudes toward family planning and ability to talk about family planning with their spouses.

It was clear that birth spacing was a topic of discussion among men, and that there was widespread understanding that birth spacing had health benefits for the mother and child, as well as economic benefits for the family. There was, however, tension between the idea of spacing births (which can reduce the number of children in a family, allowing the parents to invest more time and money in each child) and the idea that God wanted his followers to "fill the earth" by having large families.

Modern contraception methods were not discussed as the primary element in spacing births. Instead, participants noted that postpartum abstinence was the main method of spacing, which would include one of the spouses removing themselves from the household for an extended period of time, or separating beds. Men had widespread knowledge of the existence of modern methods, but without specific knowledge of the individual methods or how they worked. Apprehension about side effects were cited by many as reasons for being hesitant about use of modern methods, and participants also cited other outcomes such as infertility and infidelity among their concerns.

Strong gender norms favoring the decision-making power of men were manifest among all groups. Most respondents were in alignment that women seeking contraceptive methods without the explicit permission and involvement of their husband would be contrary to both descriptive and injunctive social norms. Men were expected to make decisions on whether to space births, to use a method, and which methods were safe to use. Discussions with other men were thus important for sharing knowledge about experiences and informing decision-making.

Discussions and a good understanding between husband and wife were also important for accessing modern contraception. If there was trust in the household, some men said they would not take issue with their wife accepting a contraceptive method without first discussing it with him, as long as she told him about it afterward. Other respondents noted this entente could involve the wife sharing information that she had learned about contraception with her husband so that they could decide on a method together.

Finally, some social sanctions to modern contraceptive use arose. Men could be seen as weak or impotent for letting their wife be the decision-maker on questions of family planning. Women could be divorced or beaten for usurping their husband's authority, with social consequences. Even nurses could be the targets of complaints or condemnation for providing a method without a woman's husband's permission, despite laws to the contrary.

Conclusions

One objective of the study was to validate the use of the SNET for exploring social norms. The SNET provided a useful starting point to think through each phase of the research process, with the rapid identification of reference groups and templates for activities to incorporate in the interviews and focus group discussions providing guidance for the development of the protocol and study instruments. The SNET succeeded in aiding the project members to understand the preferences in social exchanges between different groups of local populations because of its adaptability to the local context.

The results of the study will be integrated into social and behavior change (SBC) communication that will be implemented in the project communities. The report furnishes tables summarizing factors influencing support of men for birth spacing, and limiting family size, and recommendations for influencing these factors to increase men's support for family planning.

Recommendations

Specific recommendations coming out of the study findings include highlighting the role of healthcare providers as social influencers and building their skills in behavior change communication through training. Training on managing rumors and misinformation would also help make the different method choices more transparent. Training should also build self-efficacy for providers to enforce laws around Sexual and Reproductive Health that women do not need their husband's permission to accept a method.

Tools should be developed to support couple communication, providing straightforward information on the duration of different methods and side effects, and with discussion questions for couples to talk about together. This tool could be provided to women during health center consultations to bring home to their husbands, or during activities such as the Viva! Couple's Party.

Messaging should target men and highlight their role as responsible for the welfare of their families, promoting the benefits of modern methods for the health of mother and child, and contrasting the modern methods with the downsides of prolonged separation from their wife and children. Messaging around the importance of supporting one's wife and newborn by remaining in the household, while using a modern method to avoid closely spaced pregnancies, should be explored.

Use community-based organizations to encourage men to discuss family planning, with an educated facilitator, and share experiences and benefits of healthy spacing. Include religious and community leaders in efforts to promote family planning, particularly in Sankuru where religious constraints are major barriers to contraceptive use.

Introduction

Behaviors related to family planning

Demographic and Health Survey (DHS) are not yet available. Data from the 2013-2014 DHS showed a total fertility rate of 6.6 children per woman, a rate slightly higher than 6.3 measured in the 2007 DHS [DHS]. 20.4 percent of women were using a modern method of contraception in the 2013-2014 DHS, compared to 20.6% in 2007. Further progress in promotion of family planning in DRC depends on improving quality of services and contraceptive supply, and increasing demand for family planning among couples and support from communities.

Applying a behavioral lens, we can view family planning as a series of reproductive health behaviors, occurring in three periods: adolescence, women's prime childbearing years of 18 to 35, and in women over 35 years of age. Behaviors during the adolescent years include delay in age of initiation of sexual intercourse, delay in first marriage, and childbearing and contraceptive use during adolescence. Behaviors during the prime childbearing years include spacing of births through one or more of postpartum abstinence, postpartum separation of partners, exclusive breastfeeding during first six months postpartum (Lactational Amenorrhea Method) and modern contraceptive use. Behaviors relevant to women over 35 years of age include modern contraceptive use, with the adoption of permanent methods by men and women growing in importance in this age group.

As shown in the next table, indicators from DHS surveys show that adoption of behaviors related to family planning is suboptimal during all three periods. DRC has a high and perhaps increasing age-specific fertility rate for women aged 15 to 19 years and continuing high rates in women over 35 years of age. Approximately one in five women 35-39 years of age, and one in ten 40-44 years of age continue to bear children. During prime childbearing years, contraceptive use is low, and over one quarter of births are spaced at intervals of less than 24 months.

Table 1. *Selected fertility and family planning indicators at three periods of women's reproductive lives*

PERIOD	SELECTED INDICATORS FOR FERTILITY AND FAMILY PLANNING	VALUES FROM DHS	
		2007	2013-2014
1. Adolescence	Median age at first marriage [Women]: 25-49	18.6	18.7
	Median age at first sexual intercourse [Women]: 25-49	16.8	16.8
	Age-specific fertility rate per 1000 women, ages 15-19	124	138
2. Prime childbearing years	Total fertility rate 15-49	6.3	6.6
	Married women currently using any method of contraception	20.6	20.4
	Married women currently using any modern method of contraception	5.8	7.8
	Unmet need for family planning	26.9	27.7
	Demand for family planning satisfied by modern methods	12.2	16.3
	Births occurring 7-23 months after last pregnancy	26.0%	27.1%
3. Women 35 years of age and older	Age-specific fertility rate per 1000 women, ages 35-39	201	212
	Age-specific fertility rate per 1000 women, ages 40-44	95	97
	Age-specific fertility rate per 1000 women, ages 45-49	37	20

Social norms and family planning

Globally, the hierarchy of power and privilege typically favors men over women and is manifest in restrictive social and gender norms that negatively influence the health and wellbeing of women [Heise et al, 2019]. Literature on the spousal dynamics that influence reproductive health decision-making in the Democratic Republic of the Congo (DRC) is limited. Although a national survey found more than half of the women in the country reported reproductive health decisions were made jointly with their husbands [DHS 2014], a more recent mobile survey in five provinces of the DRC found just one-third of adults reported joint decision-mak-

ing, while nearly half (45.6%) of men surveyed said the decision to use contraception was made by him alone [Abt Associates/Prosani USAID-IHP 2020].

Men's lack of communication around family planning (FP) may contribute to the social norms that discourage adoption of family planning. These include perceptions that husbands and other family and community members do not support their use of FP, and that there is pressure from family and community members to have more children. A baseline survey conducted by the Abt Associates-led USAID Integrated Health Project (IHP) found that only one third of men reported that they could use FP if none of their neighbors or friends did, or if religious leaders disapproved. In addition, few men reported talking with family members such as mothers, mothers-in-law, or sisters about FP, despite valuing their opinion on the topic. Most men also thought that their mothers and mothers-in-law would disapprove of the use of FP, suggesting a negative perceived social norm against the use of FP and possibly a strong desire among men to comply with this perceived social norm without truly understanding important family members' viewpoints due to a lack of open communication on the subject. Only one-third of men said that they themselves approve of using FP to space or limit, with nearly a quarter noting that they did not know how they felt about this topic. Furthermore, research indicates there is limited spousal communication about health and pervasive norms that position men as decision-makers, thus inhibiting women's access to health services [Muanda et al, 2016; Garcia-Moreno, Guedes & Knerr, 2012]. A quarter of men in the DRC believe that contraception is a woman's business and men should not be involved [DHS 2014].

This study further unpacks these social-normative influences and identifies others that could improve men's ability to have informed and positive conversations with influential family and community members as well as their partners. The results of the study will be integrated into social and behavior change (SBC) communication that will be implemented in the project communities. This study combined administration of a brief questionnaire to rapidly identify reference groups influential to men's behavior around family planning with qualitative data collection through semi-structured interviews with married and unmarried men and focus group discussions with reference groups to provide a clearer picture of the context and socio-cultural norms around birth spacing and family planning methods.

The Social Norms Exploration Guide and Toolkit (SNET)

Social norms are unwritten rules of behavior shared by members of a given group or community. They dictate what people in a community believe is typical (normal) and appropriate (approved) behavior. Social norms can impact health directly or indirectly, perpetuate harmful practices or reinforce gender or other inequalities [IRH SNET, 2020].

The Social Norms Exploration Guide and Toolkit (SNET) was developed by the USAID-funded Passages Project and the Institute for Reproductive Health at Georgetown University. The SNET describes five phases in a social norms exploration to inform the content of interventions to promote changes in social norms. Tools and templates are described for each phase, which are intended to be selected and modified as appropriate.

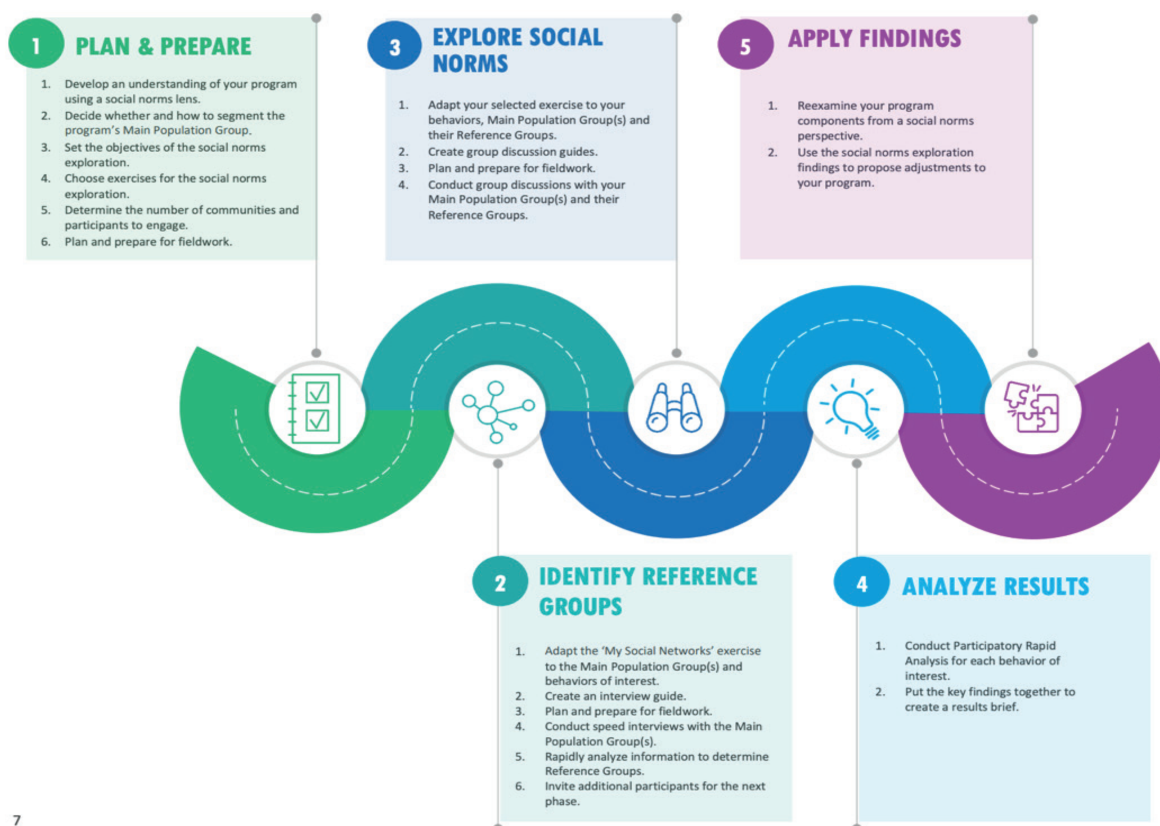
The toolkit was developed to aid project planners and implementers in conducting qualitative, participatory activities to identify the social norms of interest to a project or program, as well as which members of the community uphold and are affected by these norms. Breakthrough ACTION DRC applied the SNET to better understand norms around male engagement in FP, as well as to identify which other members of the community may influence men's decisions and actions around FP. Findings from this study will allow Breakthrough ACTION-DRC to design more relevant and effective social and behavior change (SBC) messages and interventions around family planning.

Table 2. *Glossary of key terms from the SNET*

KEY TERM	DEFINITION
Behavior of interest	The behavior your project is addressing or intending to change (in this case, discussing FP with a partner)
Descriptive norm	What I think others do. Perceptions about what others actually do, that may motivate people to behave in certain ways, simply because other people do it
Gender norms	Expectations and perceived rules for how individuals should behave according to their gender identity
Injunctive norm	What I think others expect me to do. Perceptions of approval/disapproval by others: for example, I believe that my reference group will approve if I do the behavior, or will disapprove if I do not
Reference group	The people who matter to, or have an influence over, an individual's choice to engage in a behavior
Social norms	The customary rules, often tacit, of behavior that coordinate human interactions in a social group. They represent shared beliefs about what other people do, and shared expectations about what they should and should not do

The SNET is divided into five overarching steps, including (1) a planning period, which in this application included a root cause analysis or "problem tree" exploring barriers to male engagement in family planning discussions with members of the Breakthrough ACTION-DRC program team, and development of the research protocol, (2) identification of reference groups, (3) exploration of social norms through selected activities conducted during semi-structured interviews and focus group discussions, (4) analysis of results, and (5) application of findings.

Figure 1. *Social Norms Exploration Map (Institute of Reproductive Health, Georgetown University)*



Study aims

The Social Norms Exploration Toolkit (SNET) has been piloted within communities with differing religious backgrounds in Kinshasa (https://irh.org/projects/passages/). This study sought to apply the SNET in smaller cities and rural areas far from the capital. The study had the two research aims:

Pilot test and further validate the SNET toolkit in urban and rural sites in the Democratic Republic of the Congo (DRC).

Provide data on gender roles and social norms with respect to family planning, to inform the development of social and behavior change interventions to be implemented in the DRC.

This report presents 1) findings from a participatory qualitative data analysis of the interview and focus group discussion transcripts, 2) the experience of applying the SNET in the context of the DRC, and 3) recommendations for future behavior change communication on family planning in DRC, informed by data on normative influences.

Methods

Three phases of research

The study was fielded in three provinces, including one health sub-district from each of two urban and two rural health zones in each province. Data collection took place in three distinct phases. The **first phase** used a rapid, tablet-based questionnaire to identify the people in the community with whom men stated they were most comfortable discussing family planning. Men were recruited through a random walk process whereby data collectors picked a populous street in the center of the health area and recruited a married or unmarried man from every other house as designated in a recruitment table. After obtaining consent from the participant, data collectors selected one response from a list of options including family member, friend, community or religious leader, or healthcare provider based on the participant's response to the question about with whom they would be most likely to discuss FP. Follow up questions probed respondents to further specify the reference group, for example examining how a person was related to the respondent and whether they were immediate family, older or younger, on the mother or father's side of the family, or a spouse. Probes about friends inquired if they were from a religious group, community group, from work, or a neighbor. Community leaders were broken down into professional group leaders and religious leaders. Health providers included doctors, nurses, midwives, pharmacists, and community health workers (ReCos). From these data, reference groups were constructed for each of the geographic areas (urban and rural) in the different provinces.

The **second phase** consisted of semi-structured interviews with a subsample of six married and two unmarried men per province who had participated in the rapid questionnaires. Interview participants were asked a series of open-ended questions pertaining to their experiences with family planning, their involvement in the family-planning process, and their perception of the male role in this process. Interviewers also presented participants with a fictional scenario based on real-life events (a "vignette") and asked participants to answer questions about the decision-making process taken by the characters. The objective of this technique was to understand drivers behind a very specific set of behaviors. It was also anticipated that men might speak more candidly about a hypothetical situation than they would about their own experiences. Interviews took around an hour and a half and were conducted face-to-face and audio recorded.

The **third phase** took place several days after the first two phases, allowing the data collectors time to analyze the questionnaire results from Phase 1 and recruit participants fitting the reference group criteria to focus groups (see Table 2 below), working with community health workers (ReCos) who had been trained on the recruitment process. Four focus groups were held in each of two health zones per province, one urban and one rural, with two different types of reference groups. For example, in the urban health zone in Lualaba, two focus group discussions were held with peers (men between the ages of 15 and 39 years if married, and 18 and 39 years if unmarried) and two with doctors.

Table 3. *Reference groups participating in Phase 3 focus groups by province and urban or rural geography*

PROVINCE	URBAN	RURAL
Kasai Central	• Friends (of population of interest) = men between ages of 15 and 39 yrs. • Doctors	• Wives (of population of interest) = married women between ages of 15 and 39 yrs. • Nurses
Lualaba	• Friends (of population of interest) = men between ages of 15 and 39 yrs. • Doctors	• Friends (of population of interest) = men between ages of 15 and 39 yrs. • Wives (of population of interest) = married women between ages of 15 and 39 yrs.
Sankuru	• Friends (of population of interest) = men between ages of 15 and 39 yrs. • Nurses	• Religious leaders • Nurses

The purpose of the focus groups was to understand how reference groups communicate their attitudes, beliefs, and behaviors about family planning to the men they influence. The focus group discussions included two activities from the SNET, a portion of the vignette used during Phase 2, and an activity called the "5 whys" that broke the participants up into small groups and, with a facilitator, took them through a root cause analysis of one of four behaviors around male engagement in family planning. Participants were asked to give a reason why a behavior was or was not practiced, and the facilitator then asked why that factor or reason existed in the way it did, and so on until the facilitator had asked "why" five times. The next table illustrates a series of "why" questions in the focus group guide.

Table 4. Example of sequence of "why" questions addressed by break-out groups during the focus groups

BREAKOUT GROUP 1 WILL DISCUSS THE QUESTIONS:
1. Some men do not talk to their wives or partners about how many children they want to have in total for their family. Why is that? 2. When a couple has decided they will use FP, some men do not allow their wife or partner to freely or independently choose what FP method to adopt. Why is that?
BREAKOUT GROUP 2 WILL DISCUSS THE QUESTIONS:
3. Some men do not talk to their wives or partners about how much time they want to wait in between having children. Why is that? 4. When a couple has decided they will use FP, some men do not allow their wife or partner to freely or independently choose what FP method to adopt. Why is that?
BREAKOUT GROUP 3 WILL DISCUSS THE QUESTIONS:
5. Some men are not the one to initiate conversations about FP with their wives or partners. Why is that? 6. When a couple has decided they will use FP, some men do not allow their wife or partner to freely or independently choose what FP method to adopt. Why is that?

Study participants

The main population of interest for this study was married men between the ages of 15 and 39 years old in the three provinces of Kasai Central, Lualaba, and Sankuru. Unmarried men between the ages of 18 and 39 years old were a secondary population of interest. Approximately 75 married men and 25 unmarried men per province, or 317 men total, were recruited for the rapid questionnaire, and a subset of these (6 married and 2 unmarried men per province) were invited to participate in the semi-structured interviews as well. For the focus group discussions, two focus groups of 6 participants each occurred with each reference group selected per site, resulting in 8 focus groups, or 48 participants, per province.

Table 5. *Methods and sample frames*

PHASE	DATA COLLECTION METHOD	OBJECTIVE	POPULATION	N
1	Rapid, tablet-based questionnaire	Identify reference groups who influence men around family planning	Married and unmarried men 15-39 years and 18-39 years old, respectively	317
2	Semi-structured, face-to-face interviews	Examine how social norms affect male involvement in FP; Examine men's experiences with family planning, their involvement in the family-planning process, and their perception(s) of the male role in this process	Married and unmarried men 15-39 years and 18-39 years old, respectively	24

PHASE	DATA COLLECTION METHOD	OBJECTIVE	POPULATION	N
3	Focus group discussions with identified reference groups	Understand how reference groups communicate their attitudes, beliefs and behaviors about family planning to the men they influence	Friends (of population of interest) = men between the ages of 15 and 39 years Wives (of population of interest) = married women between the ages of 15 and 39 years Nurses Doctors Religious leaders	144

Data collection

Data collection for this study took place from March 11 – April 1, 2022. All data collectors and supervisors were trained in human-subjects research. Given the ongoing COVID-19 pandemic, precautions were taken including masking and a short assessment of potential symptoms and exposure. The data collector training took place in person at Breakthrough ACTION's office in Kinshasa, and staff accompanied the local research firm, ALMA Research Services, for a pre-test of the instruments in the Ndjili neighborhood of Kinshasa. Breakthrough ACTION staff, ALMA leadership, and representatives from the National Program for Reproductive Health (PNSR) provided supportive supervision to data collectors in each of the three provinces.

ALMA programmed rapid questionnaires onto tablets to collect data on reference groups in each health zone. Qualitative data from semi-structured interviews and focus group discussions were audio recorded and then transcribed and translated word-for-word into French for analysis. Interviews and focus group discussions were conducted in French, Tshiluba, Lingala, or Swahili, depending on the preference of the participants. Two randomly selected 5-minute sections of each transcript were spot checked and validated against the audio by an "expert transcriber" for accuracy. If this reviewer had concerns about the quality of the transcript, the rest of the transcript was then reviewed and sent back for corrections.

There were several challenges to data collection for this study. During Phase 1, data collectors found that many men were not at home at the time of day during which they were recruiting participants. Data collectors returned to the same homes in the afternoon or evening of the same day, or asked other members of the household when men would be home. There were also logistical challenges, with some provinces only having one flight a week, and delays in research activities due to poor roads and rainy conditions. Some data collection teams had to devote a full day for travel to the provincial health department (DPS) to present on the study and obtain approval from local health authorities. Finally, data collectors encountered challenges when trying to convene a focus group of health providers, both for doctors and nurses. Given the paucity of providers in some health areas, and their conflicting schedules, finding a time that worked for 6 providers at once proved difficult.

Data analysis

Data analysis was conducted through a participatory 5-day workshop, convening data collectors, Breakthrough ACTION-DRC program staff, and representatives from the Ministry of Health to read through the transcripts and discuss emerging themes and insights, first by site, then by province, and finally in plenary. Prior to the workshop, a process of inductive coding was undertaken with a subset of transcripts using ATLAS.ti and codes developed through this process were grouped into overarching themes. At the same time, notes from the "5 Whys" activity were organized into themes by a second member of the research team, and themes were compared across the two exercises. Six overarching themes were shared with the participants of the data analysis workshop for validation and the addition of any other significant and reoccurring themes as they read through the transcripts.

Each participant was asked to read two semi-structured interview transcripts and to discuss their findings with a partner who had been assigned transcripts from the same province and geography (urban or rural).

Small teams of four participants were assigned to read transcripts from each province and came together to discuss similarities and differences between the urban and rural areas as a group. The groups also engaged in the development of subthemes (with supporting citations) for each larger theme.

After the first day of the workshop, participants provided feedback and validation of the overarching themes, which included splitting two of the themes into their separate components and the suggestion of two additional themes. The same process was used to analyze the transcripts from the focus group discussions, and at the end of the workshop the small groups presented out their findings on all the qualitative data from their province to the rest of the group for discussion. After this process, all the data and analyses carried out were validated in a plenary session by the whole team. Recommendations were proposed for the future application of these data to the FP interventions in an approach of adaptation and learning.

Results

Phase 1: Reference group questionnaires

Across the three study provinces, a total of 317 men were recruited door-to-door for participation in reference group questionnaires. 75.4% of the men were married, and all men were between the ages of 15 and 39 years old, with an average age of 29 years. The demographic characteristics of Phase 1 participants are presented in table 5. Results from these questionnaires informed construction of reference groups in each province.

Table 6. *Demographic characteristics of Phase 1 respondents*

(N=317)	N	%
AGE IN YEARS		
15-19	32	10.1%
20-24	64	20.2%
25-29	62	19.6%
30-34	73	23.0%
35-39	86	27.1%
MARITAL STATUS		
Marié à	239	75.4%
Non marié	78	24.6%
PROVINCE		
Kasai Central	105	33.1%
Lualaba	101	31.9%
Sankuru	111	35.0%

Men were asked to identify with whom they felt most comfortable discussing family planning. For each province and geographic site (urban/rural) different sample frames were developed. Table 6 shows the most-cited group (green) followed by the second most-cited reference group (yellow). The most cited group across all provinces was healthcare providers at 47%, with the majority of those citing healthcare providers in urban areas saying that they were most comfortable talking to doctors about family planning (47%), compared to respondents in rural areas who were most comfortable talking to nurses (66%), perhaps due to there being fewer doctors in these areas. The second most cited group was friends or peers (24%) followed by family members (20.2%).

Some differences were observed by province, with respondents in Lualaba most frequently citing friends rather than providers, and those in Kasai Central citing family members (and their wives in particular) more often than friends. Of respondents who said they would be most comfortable talking to their friends about family planning, those in Kasai Central were equally likely to say they talked to friends from work/a professional group (36%) or their neighbors (36%), while those in Lualaba were most comfortable talking to friends from a community group (53%) and those in Sankuru were most likely to cite friends from religious circles (42%). There was no difference seen in urban and rural responses, with the overall tendency showing most comfort with talking to friends from community groups (39%). Among those who cited talking to or being comfortable talking to family members, participants in Kasai Central and Lualaba said they were most likely to talk to their partners, at 50% and 54% respectively. Conversely, none of the respondents in Sankuru said they would be most likely to talk to their spouse, instead reporting that they would be most likely to discuss family planning with other men in their immediate family, such as brothers (50%) and fathers (42%).

Table 7. *Types of community members with whom men feel comfortable discussing family planning*

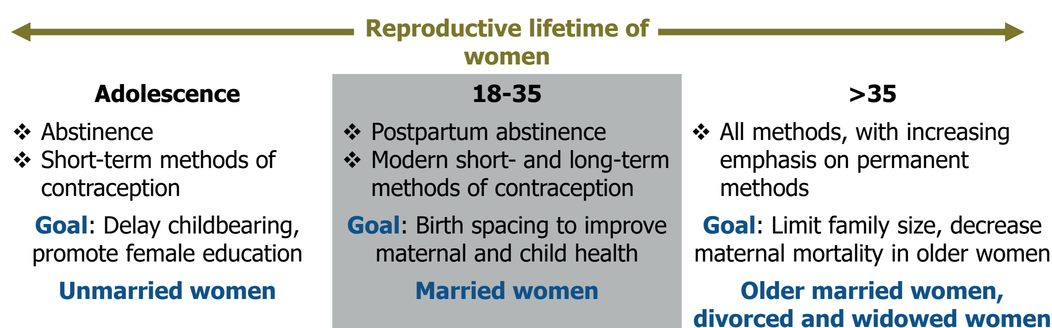
	REFERENCE GROUP CITED - % (N)					
	FAMILY MEMBER	FRIEND	COMMUNITY OR RELIGIOUS LEADER	HEALTHCARE PROVIDER	OTHER/ DON'T KNOW	TOTAL
Kasai Central	24.8% (26)	13.3% (14)	7.6% (8)	52.4% (55)	1.9% (2)	**100% (105)**
Lualaba	25.7% (26)	37.6% (38)	4% (4)	26.7% (27)	6% (6)	**100% (101)**
Sankuru	10.8% (12)	21.6% (24)	6.3% (7)	60.4% 67)	0.9% (1)	**100% (101)**
Total	**20.2% (64)**	**24% (76)**	**6% (19)**	**47% (149)**	**2.8% (9)**	

Phase 2 and 3: Qualitative analysis of transcripts from semi-structured interviews and focus group discussions

The scope of family planning

Among reproductive health specialists, family planning has a broad scope. It is relevant to women's entire reproductive lifetimes from menarche to menopause, and to unmarried, married, divorced and widowed women. Contraceptive methods include short- and long-term temporary methods, and permanent methods. Family planning can have a range of goals, from delaying the start of childbearing and promoting female education, to birth spacing, to limiting family size and decreasing maternal mortality in older women. However, the scope of family planning communicated by participants in interviews and focus groups was narrower and restricted, and is indicated by the shaded area in the central column of Figure 2.

Figure 2. *Scope of family planning communicated in interviews and focus groups (central column - shaded area)*



The core of understandings of "family planning" across different types of study participants was birth spacing among married women, through either postpartum abstinence, or modern short- and long-term methods of contraception. The needs of adolescents and other younger, unmarried women, and women near the end of their childbearing years, rarely came up in interviews and focus groups.

The following series of exchanges from a focus group with nurses in a rural health zone illustrate this dominant conception of the scope of family planning, that family planning primarily concerns birth spacing for married women. It follows that a main role for health care providers is to explain birth spacing and instruct couples on how to space their births. In interviews and focus groups, it often appears that "birth spacing" and "family planning" are synonymous or interchangeable.

Table 8. *Discussion of birth spacing during focus group with rural nurses*

E : What about the men who come to you, what do they already know? What do they know about family planning?

G5 : They know that family planning is what gives him a way to be able to space births. Between two children, what can a man do so that the children are spaced out. Maybe someone else has an idea, yes G1?

G1 : Huh.

E : G1 go ahead and speak.

G1 : We learn to space births because a lot of men force it. For births that are not spaced, the children suffer from malnutrition because the spacing was not respected.

E : And the men of this community, what do they know as a lesson?

G1 : We teach them and they have stared to create a little space between children.

E : Yes, it's as if, it's as if someone else, yes G2?

G2 : Yes, regarding family planning…At each time we conduct educational sessions to instruct them on how to space births.

Focus group with providers in rural Sankuru

Benefits of birth spacing

The transcripts highlight greater knowledge of the benefits of birth spacing in general, rather than the benefits of specific contraceptive methods. Through the data analysis workshop, many of the benefits fell into four major categories: functional benefits, social benefits, economic benefits, and health benefits.

Within functional benefits, some examples study participants highlighted include improved overall living conditions (housing, clothing, food, etc.) and the increased likelihood of well-educated children. One participant notes,

"It's important that we can space for to be able to see clearly how we can make the children grow up well and study so that they can be useful to society." –man, urban Kasai Central

Nurses' statements strengthen the basis of this benefit,

"If we do not adhere to this method we will have trouble enough because to have children, a lot of children, to educate them, to feed them will pose a problem, but thanks to your methods here that spaces them taking into account their social lives."– focus group with nurses, urban Sankuru

Through birth spacing, families are able to manage more easily and resources are less limited. This benefit seems to be known in both the community and provider settings. Social benefits include a balanced family with open communication that promotes healthy children. The social benefits also extends outside of the family, as such balanced families are admired within the community. One participant in a focus group describes,

"Because when they will follow the advice, they will space births, the children will be in good health, the mother in good health, the parents, the father as well in good health. So they will be a model couple, an example couple who others can go to sometimes to ask for advice." -man, urban Sankuru

Couples are aware that birth spacing can decrease the financial burden on the family unit. The financial burden sometimes is mentioned first, followed by benefits for the health and nutrition of the child.

"It's important when you space births so that you can save even a little bith of money at home." – man, rural Lualaba

"Ok. These people remembered that in life it is just necessary to space because if you don't space there

will be only expenses in the house and even the mother will not be, um, in good health, the children as well, the one who is now in hand while the mother is pregnant. And the child who is in hand, who, who is breastfeeding, nursing, will have difficulties for his growth. Now the child will be sick all the time, all the time. There will be divorce in the house, and people now, now they understand. They now come to the health center to learn about different family planning methods."– focus group with nurses, rural Sankuru

There is widespread understanding of the health benefits of birth spacing for both mothers and children. A participant explains,

"Spacing births so that the children they will have will be in good health and avoid certain diseases." – man, rural Kasai Central

In the focus groups, nurses also supported this sentiment,

"What will happen to them is the spacing of the births because this woman will be able to rest. She will be in good health." – focus group with nurses, rural Sankuru

Women's recovery after birth was mentioned multiple times as a significant benefit of family planning. By improving maternal health, the family unit is also strengthened. Messaging emphasizes the importance of protecting women and mothers,

"They have information according to which, the first thing is to protect the woman, because if she isn't giving birth all the time, according to her cycle of childbearing, she will be physically strong for many years – there they have this information already…we have taught them that, the importance, so that the woman will live for many years. The second thing, it's to make sure that these children will grow up in good health and be educated, those are the big things, the advantages. " – focus group with health providers, rural Kasai Central

Most benefits of family planning mentioned were at the family level. This indicates that the benefits that strengthen and promote the state of the family unit are most relevant in these communities.

Norms around birth spacing

Two categories of behaviors for spacing of births were mentioned, beyond use of modern contraceptives: 1) Absence of the husband / male partner during the postpartum period or absence of the recently-delivered woman during the postpartum period, 2) Abstinence from sexual relations by separation of beds, or by man seeking relationships with other women. A third category, exclusive breastfeeding / lactational amenorrhea method was not mentioned or described, and some statements about breastfeeding were erroneous. The first two (absence and abstinence) were described both as descriptive norms (what people are doing) and injunctive norms (what community members recommend that people do). They are also both at times discussed as part of the tradition or culture.

Table 9. *Options for birth spacing described in interviews and focus group*

OPTION FOR BIRTH SPACING	EXAMPLES
1) Absence of the husband / male partner during the postpartum period or absence of the recently delivered woman during the postpartum period 2) Abstinence from sexual relations by separation of beds, or by man seeking relationships with other women	**P:** another could travel so that he creates a gap so that the child is left to grow; **E:** yeah, someone could go on a trip, yes mama, **P:** someone else could marry another woman, so that while the child is growing, he is at another woman's house; **E:** ok, someone could marry another woman; another idea, what method… **P:** someone else could just stay and say that, we're adults, let the child grow; he's there – he abstains but he's there Focus group with wives, rural Kasaï Central

OPTION FOR BIRTH SPACING	EXAMPLES
3) Exclusive breastfeeding / lactational amenorrhea method	Exclusive breastfeeding not understood as method of birth spacing. Breastfeeding even viewed as potentially dangerous to the child: **P:** You argue a lot with your wife – you have a baby in the house, you will notice that this child will become very sick, it could even die **E:** hum hum ! **P:** so it's a method, it's a time during which the woman breastfeeds the child, she gives it her hormones which are transmitted to the child! And now when she transmits her hormones there with a lot of worries, that will weaken some of her functions that she's giving to the child, and the body of the child won't respond well, and what can the child do? That can made the child sick, the child could die. Focus group with peers, urban Lualaba

Norms around family size

Conflicting community values, one promoting spaced births and the other encouraging large families, complicates family planning perceptions and thus messaging. Family planning in order to limit family size was not reported or described by study participants. As such, "norms around limiting family size" was not an identifiable theme in the data. In some focus groups with men, there was frank hostility to limiting family size, sometimes based on the teachings of churches. The concept of "fill the world / remplir la terre" was mentioned in some focus groups with rural men, a concept obviously at variance with limiting family size. The only one who can limit family size is God.

Table 10. *Discussion of limiting family size during two focus groups with men*

E: Does even the church not teach about birth planning? **P:** In church they say "put as many on this earth as you can". To abort is a sin. It's necessary just to procreate to fill the earth. Focus group with men in rural Lualaba
P: In church they say: God said to fill the earth. **E:** The earth, fill it. **P:** and so we have no interest and they say it's evil, they have demonized spacing children, for example, by the methods we could apply today or tomorrow, for example, condoms, injections, pills, they say it's... it's strictly evil because God said "come and fill the earth", so when you're in a couple, you have to give birth. **E:** ok ! **P:** Only God himself can stop the births. **E:** ok only God himself can stop the births. Focus group with men in urban Lualaba

While some couples who use family planning to space births are seen as a model family within the community, other participants noted that there still exists the desire to have many children. A participant in Kasai Central explains a key disadvantage of having only one child,

"Because they think that having a lot of children is an advantage, they say that one of them will remember me; if he has one, it won't remember him." – woman, rural Kasai Central

Knowledge of modern contraceptives, method mix

Another theme identified during through the data analysis workshop was the knowledge, and lack thereof, about different modern contraceptives. Health care providers, and men themselves, reported that men in particular were ill-informed about modern contraceptives. They were not familiar with the full method mix, nor the characteristics including benefits and risks of different individual methods of contraception.

The most mentioned methods were long-acting contraceptives (implants and injections) condoms, and IUDs. Menstrual cycle awareness methods were among the least mentioned. In Sankuru, the condom was the most mentioned modern method while in Kasai Central and Lualaba, the implant was the most frequently mentioned. Additionally, Sankuru participants mentioned injections more frequently than participants in the other provinces.

Table 11. *Contraceptive methods mentioned by province*

	CONDOM	IUD	IMPLANT	INJECTION	RHYTHM METHOD
Kasai Central	100	37	125	28	0
Lualaba	71	40	122	39	2
Sankuru	192	35	142	45	10
Total	363	112	389	112	12

Many of the trends across the different methods were similar in both rural and urban areas; however, injections were more frequently mentioned in rural areas and IUDs were more frequently mentioned in urban areas.

Table 12. *Contraceptive methods mentioned by rural v. urban designation*

	CONDOM	IUD	IMPLANT	INJECTION	RHYTHM METHOD
Rural	148	46	180	61	8
Urbain	215	66	209	51	4

These results differ from the 2013-2014 DHS data where the most frequently cited methods in order of importance are the male condom, injectables, the pill, female sterilization, and the female condom. According to the 2013-2014 DHS, the most used modern family planning method in Lualaba (formerly Katanga) was the male condom followed by injectables. The male condom was also the most used modern method in both Sankuru and Kasai Central. The repartitioning in 2015 may have altered these results slightly but the male condom remains the main cited method of family planning.

Through the data analysis workshop, groups were able to further analyze this theme across the transcripts. Workshop attendees noted that most study participants were aware of the general concept of family planning as a method to space births, but that there were sparse mentions of the multitude of available mechanisms and a lack of extensive discussion on the specifics of the methods. One nurse in Kasai Central describes,

"There are those who know, others who doubt. In terms of teaching, out of one hundred, seventy-five percent already have this knowledge" – focus group with nurses, rural Kasai Central

While most study participants were aware of the benefits of modern methods of contraception, this general knowledge of the benefits does not necessarily equate to a comprehensive understanding of all available methods. In a semi-structured interview, a rural Lualaba husband notes,

"The methods, we teach them but- we know them but it's difficult to list them" – married man, rural Lualaba

Although information on the plethora of available family planning methods may be shared with community members, the current packaging or communication may not be the most effective way to engage men and may lead to information overload. Additionally, the data analysis workshop revealed knowledge discrepan-

cies between men and women. According to the interviewed doctors, women are more informed and knowledgeable about family planning methods. Men know much less, partly due to their lack of interest:

> "Yes, I would say that men know little because they are also less interested" -Doctor, urban Kasai Central

These findings illustrate the need for clear messaging on all available methods of family planning in an easily digestible format with a specific focus on targeting the men within the community.

Concerns about modern contraceptives

Study participants discuss both the physical side effects and social risks of modern family planning methods. Social risk is defined as the risk to present and possible future social relations, for example when use of a modern contraceptive by a woman leads to strained relations with her husband and his family (Eaves 2014). During the data analysis workshop, attendees highlighted social risks, specifically, various mentions of marital stress as a concern of family planning. While based on the benefits previously mentioned, use of family planning may seem to have a beneficial effect on martial relations; however, discussions with study participants reveal that family planning can pose risks to the stability of marriages. One participant explains,

> "there will be tension with the consequences of these tensions maybe leading to harmful outcomes such as separation or dissatisfaction in the home." -man, urban Lualaba

Concerns regarding separation, divorce, and prostitution are all mentioned as social risks by study participants. Caregivers are also aware of community concerns regarding possible social consequences, a nurse notes,

> "That happens here because many women, while she is choosing a method to space births, behind that she will get into prostitution. That why the man says 'I must choose the method myself'." – focus group with nurses, rural Sankuru

These social risk concerns can counteract or completely cancel out appreciation of the benefits of birth spacing and family planning. These concerns are not easily addressed by medical professionals. Along with concerns regarding social risks, there is considerable concern regarding the physical side effects of modern family planning methods. Concerns regarding side effects range from disease,

> "If they use it, they can get other diseases" -man, urban Lualaba

to cancer,

> "he can accept and then cancer manifests itself, or other diseases that can create problems in the family" man, urban Lualaba

to excessive bleeding,

> "it's the woman who loses blood, she could die" – man, urban Kasai Central

These concerns regarding the physical side effects may relate to 2013-2014 DHS data on choices and information on contraceptive methods. Although varied depending on the utilized method, only 57% of users of modern methods reported that they were told about side effects or problems that might occur while using the method. The lack of comprehensive care could be contributing to the spread of misinformation and rumors regarding physical side effects. The results of this study indicate broad community knowledge of the benefits of family planning but multiple misgivings regarding the consequences resulting in general concern and hesitation.

Gender norms

The most prevalent norm that emerged around gender was that of the role of the man as the head of the family. In this role, the man is the final decision-maker when it comes to whether or not to have another child sooner rather than later, and what, if any, contraceptive method his partner should use. In many cases, the husband may want to have more children, while his partner, who bears the burden of childrearing and pregnancy, is inclined to wait. According to one married woman in rural Kasai Central,

> "The man wants to have a lot of children, and he says to himself, 'if the woman receives a method, she won't give me a lot of children'." - woman, rural Kasai Central

Similarly, another participant noted that the man's desire to have many children puts the woman in the position of finding ways to space or limit childbearing. Rather than collaborating, their reproductive goals are in opposition.

> "To produce children it's the man. But to delay it is the woman who says 'no, we should look for preventive measures." - married man, urban Sankuru

Religion also reinforces these gender norms, supporting the authority of men in the household, and reinforcing their role in decisions on when to have more children and family size. References were made to children being a gift from God, and one man noted that the authority of a man over his wife stems from God,

> "The word of God says that the woman must be subject to the word of her husband; how come? – you are responsible, the woman is the fruit of your ribs." - man, urban Kasai Central

Given the greater authority that the husband wields, his preference around number of children and whether to use contraception takes precedence over the woman's desires. The man's role as head of the family also signifies that he is responsible for the wellbeing of his wife and children. Women were seen by some participants as being weak or uninformed, and therefore incapable of choosing a contraceptive method that is safe for her. If a woman were to suffer side effects from using a contraceptive method, the man would be responsible regardless of whether or not he was involved in choosing the method. Therefore, many husbands may see their role in choosing a contraceptive method as one of ensuring that their partner is not exposed to anything that may be dangerous. One woman explained,

> "Because the woman can go and choose a method which she hasn't mastered, the man in his walks might have more understanding about the methods than his wife, the wife could take the implant or the injection and this is what had consequences for her husband's friend's wife, she can trust the method without knowing the consequences, and when the consequences happen, the man will start off telling her 'look, you went and took whatever, look what is happening to you today'." -woman, rural Kasai Central

A married man in Sankuru gave similar reasoning, stating,

> "Because I'm the man. My wife, she's always a woman. She has a weak mind, you understand." - married man, rural Sankuru

In both cases, the woman is accepted as the weaker sex, who must be protected from unsafe or unhealthy methods and her own ignorance of potential consequences. Because the husband is responsible for the wellbeing of his household, any negative consequences of his partner's choice to use a family planning method, such as the cost of visiting the health center or treatment, will fall to him.

As social norms unanimously position the husband as the head of the family, any effort by his partner to take family planning into her own hands may be seen as a challenge to his authority. In a focus group with doctors in Lualaba, one man stated,

> "There are certain men who tell themselves, if the woman…herself chooses the method, it's as if they would say the man isn't felt…isn't considered as the one responsible…for the home"– focus group with providers, urban Lualaba

A participant of another focus group in Lualaba agreed,

> "Me, I think it's difficult for the woman to make decisions herslef. It would be as if, me, I were no longer the voice of authority in the house over my wife " - man, rural Lualaba

This challenge to authority was shown to extend as far as the nurse or doctor who provided the method. Said one married man in rural Kasaï Central,

> "If she did such a thing without consulting me, and the person who put it there, I would bring a complaint against all of them so that they would explain to me how they came to do something like that without consulting me." - Married man, rural Kasai Central

Even though legally women are allowed to adopt family planning methods without their husbands' consent, widespread gender norms promoting male authority prevent women from accessing these methods, and may even lead some health providers to refuse to provide a method without the husband present.

While participants broadly agreed that the man should have the final say in the use of a family planning method, there was general support for engaging in dialogue as a couple.

> "Usually it's done like that so that the husband remains the only one responsible for his wife, because she can't do it herself, it has to be done together. She has to first share the information with her husband, because she doesn't know if the husband will approve of her opinion or not; you can't use it directly, no." - unmarried man, urban Sankuru

This dialogue could involve the woman gathering information about a method and sharing it with her husband, for him to give his approval. Alternatively, one man noted that if a woman were offered a method at the health center, it would be allowable for her to accept the method, as long as she then returned home and shared information on the method she had received with her husband:

> "Me I see that if there is understanding between the man and the woman, the woman can't go to the center and come back without saying, there where I went was like this – I meet and she brings me back the booklet: 'there at the center, they injected me with the medicine for three months'. Once three months have passed she'll go back to the center there to renew it, there's no problem." - man, urban Kasai Central

There is also support for men accompanying their wives to the health center.

> "There are other who accept, okay, as he accompanies his wife to the center, that's good. Such a man will always be regarded well, because he does it for his household, and not for someone else's household." - married man, rural Kasai Central

A man who accompanies his wife to the health center would be seen in a positive light because he would be seen as a responsible husband looking after the wellbeing of his family, fulfilling his role as head of the household.

Sanctions for those who act contrary to social norms

In the SNET, a sanction stands in contrast to a reward. Rewards are "the benefits to following the norm", while sanctions are "the consequences of not following the norm". Analysis of rewards and sanctions serves to answer the question "Why do people comply with social norms" and "help unpack the 'black box' of how norms operate".

During the participatory data analysis workshop, there was some confusion over whether sanctions referred to negative consequences of a given behavior in general, versus social sanctions that relate to disapproval or punishment by others in the community. Further complicating the situation, the range of meanings of sanction in French differs from English.

Nevertheless, participants in the workshop were able to identify several social sanctions, following the definition in the SNET. Many of these sanctions arose around women accessing family planning methods without their husband's consent. Social sanctions on the husband, whether related to his perceived weakness or lack of authority in the face of his wife taking family planning into her own hands, or due to social pressure to have many children, could put pressure on him to seek divorce. The vignette presented to participants during the interviews and focus group discussions involved a couple who disagreed about using a method. The wife, Safi, wanted to use a method, whereas her husband, Mbuyi, was unsure. Many responses to this scenario stated that if the couple could not come to an agreement it would be grounds for divorce:

> "Not everyone will accept, you just said the first time around that when the woman also has already been given the injection, and me as well how can I say it's a lie! I can't accept, it's an important point even if he says whatever they will always finish in divorce, because the woman as well has already refused to listen to the man."- man, urban Lualaba

Women's lack of fertility may also be a link between disagreement or "unauthorized" use of FP and divorce and suspicions of infidelity.

> "...There are always consequences, there are always consequences. She can go like that and the date expires but she still doesn't conceive and if you come tell me that - I didn't know – that will again create problems in the home." - unmarried man, rural Lualaba

Some focus group participants contended that women who do not listen to their husbands would be viewed poorly, insinuating that such behavior would be grounds for divorce, “infidelity and imbalance” (Doctor, urban Lualaba) or even physical violence. Thus, there is a risk of community disapproval resulting from norms that position the wife as subordinate to the wishes of her husband, in a case where she appears to act contrary to his wishes.

> “The man can get angry if the woman no longer listens to him…the man might think to take another wife. Since he sees that his wife has become unsympathetic, he can think of taking another wife.” - nurse, rural Sankuru

Social expectations around what steps men might take in the face of a wife who is seen as noncompliant may reinforce norms that prevent women from taking responsibility for their own reproduction. In some instances, community acceptance of gender-based violence may also reinforce adherence to the norm of women deferring to their husband’s will around use of family planning. One man recounted, *“...my wife disrespected me and I beat her….” (man, urban Lualaba).* While these consequences may not themselves rise to the level of social sanctions, they result from descriptive norms about what another husband might do if his wife did not listen to him or chose to use a family planning method without his approval, as well as injunctive norms about what his community would expect him to do in such a situation.

Not only women faced sanctions for going against social norms. Men could also face ridicule for using family planning, being seen as “impotent, unable to reproduce” (man, urban Sankuru), or letting their wife decide on a method without them. When asked what the community would say about a man who listened to his wife and accepted her choice of a method, one man explained, “*he will be seen as a cowardly man, even at his home, in the house, people won’t understand”. (man, rural Kasai Central).* However, an opposing sanction existed among some respondents, with one group of men in rural Lualaba saying that a man who refused to accept family planning for his wife when pregnancy would put her life at risk (due to possibility of a tubal pregnancy) was “worse than a criminal – it’s as if he’s sending his wife to her death.”

Table 13. *Description of disapproval of a man not prioritizing health of his wife*

P: we had made it for the husband that ‘if your wife…gives birth again, then your wife will die’, why not that we had explained that she was having problems with her tubes and here and there. So then, it was necessary that we could um…that’s why we didn’t hear anything. It’s a father, her father there came to my father here to ask his ideas, so her husband was in question. Yes, yes. We my father said well, if that’s it. And in the interest of at least saving her life…

E: hum

P: ah, that, it’s necessary, really. And they came back to the hospital and they accepted, hum, after that the mama there wouldn’t give birth, yes, well , but in that case there. In the opposing case, if these men didn’t accept…to do that at least, to do that in favor of his wife…

E: hum hum

P: In that case he’s, he is worse than a criminal.

E: Yes, he is worse than a criminal

P: Yes, yes, he is worse than a criminal, it’s as if he is sending his wife to her death.

Man, rural Lualaba

Male nurses were also a potential target of disapproval and suspicion of infidelity, with one man observing,

> “For example, if the wife goes there alone like that without her husband and then her husband learns of it, he can bring a complaint that the nurse went out with my wife, or the nurse cheated with my wife, or why else would he have done that to my wife without warning me; they will condemn the nurses.”- unmarried man, rural Kasai Central

Nurses could be condemned in the eyes of the community for providing contraceptive methods to a woman without her husband's permission, creating a barrier to care for women whose husbands are against the use of family planning methods.

Conclusion and Implications

Application of the SNET

L'un des objectifs de l'étude était de valider l'utilisation du SNET pour l'exploration des normes sociales. One objective of the study was to validate the use of the SNET for exploring social norms. The SNET provided a useful starting point to think through each phase of the research process, with the rapid identification of reference groups and templates for activities to incorporate in the interviews and focus group discussions providing guidance for the development of the protocol and study instruments. In addition, the SNET is a relatively simple tool in its application. It succeeded in aiding the project members to understand the preferences in social exchanges between different groups of local populations because of its adaptability to the local context. Phase 1, with its rapid analysis of different reference groups rooted in responses from local men, allowed the study to be tailored to recruit the most influential populations around FP at each site.

Inductive coding confirmed that the SNET-informed approach resulted in discussion of social norms and sanctions in the transcripts, particularly around birth spacing and gender norms. However, despite the focus on norms in the methodology, the qualitative data collected reflected a range of factors that spanned the individual and structural as well as the social. While the SNET serves to examine the impact of social factors on a behavior of interest, formal application of the toolkit requires continuous commitment to keeping the focus on normative factors and a shared understanding of social norms by participants at all steps of the process. Specific strengths and weaknesses of each methodological feature of the SNET are presented in the next table.

Table 14. *Strengths and weaknesses of each methodologic feature of the SNET*

SNET METHOD	ADVANTAGES OF THIS METHOD	THREATS TO VALIDITY	KEY INSIGHT OR RECOMMENDATION
Method 1: Identification of reference groups	• Rapid analysis of which community members men consider influential to their behavior around FP; • The reference groups can be tailored by site	• Groups identified were not limited to reference groups, but included other sources of information about FP such as healthcare providers and RECOs	Men are not influenced only by social norms, but also by knowledge of FP methods. Inclusion criteria for reference groups should be developed
Method 2: Vignette of a couple making decisions about FP	• Presents a specific scenario to respond to; • Men may feel more comfortable responding to questions about a hypothetical character	• Certain aspects of the scenario were confusing or not well understood; • Some men may not feel comfortable responding to certain questions	Future applications of the SNET should keep the vignette short and straightforward.
Method 3: Focus groups with site-specific reference groups	• Triangulation between men's perceptions of what others in the community expect of them, and what these influential persons actually expect; • Different reference groups may hold different norms	• Groups identified were not limited to reference groups, but included other sources of information about FP such as healthcare providers and RECOs	Healthcare providers such as doctors and nurses, while not necessarily reference groups, are still privy and subject to the social norms operating in their communities

SNET METHOD	ADVANTAGES OF THIS METHOD	THREATS TO VALIDITY	KEY INSIGHT OR RECOMMENDATION
Method 4: Five Whys exercise	• Delves further to determine root causes of norms or behaviors	• In many cases, the "5 whys" provided were rather 5 separate responses to the initial "why", instead of digging into the underlying norms	This exercise was too complicated, requiring the moderator to decide on the spot which reasons were most related to norms; Moderators were not experts in social norms
Method 5: Participatory analysis workshop	• Collaboration between different stakeholders; • Intercoder discussion to compare and contrast findings from urban and rural sites ; • Validation of themes; • Collaborative synthesis of key insights	• The social norms framework is not intuitive and certain concepts were misunderstood; • Insufficient time for analysis	If participants do not see social norms as a priority, it is difficult to maintain a focus on social factors; Workshops should be longer than 5 days or based only on a subset of data

The staff of the National Reproductive Health Program (PNSR) who participated in the study recognized the value and applicability of the SNET to the DRC context. They made recommendations for application of study results to the promotion of family planning in the DRC. They also advocated for communicating results to stakeholders at every opportunity. For the PNSR, success in reaching men and building their support for family planning has the potential to greatly increase acceptance and uptake of family planning. These men can be reached through their networks of family, religious and community groups, and workplaces such as local and professional associations, churches, parents' groups and or the circles of religious leaders. In addition, the PNSR noted the importance of collaboration between the government and local leaders to facilitate the promotion of family planning activities.

Implications for promotion of birth spacing

Birth spacing is viewed as synonymous with family planning by many or most study participants. The benefits of birth spacing for the mother and child are widely recognized, and norms related to birth spacing were easily elicited. The next table summarizes the findings on factors influencing support of men for birth spacing. Couples pursue birth spacing through both non-contraceptive and contraceptive methods, as shown in the next table.

Table 15. *Factors influencing support of men for birth spacing*

BEHAVIORAL OUTCOME	BIRTH SPACING WITHOUT MODERN CONTRACEPTIVES	BIRTH SPACING WITH MODERN CONTRACEPTIVES
Options for achieving the outcome	• Woman stays with her relatives after childbirth, delays return to home • Man migrates elsewhere for work after childbirth • Man and woman sleep in separate beds • Man pursues relationships with other women	• Modern contraceptives, most commonly Condom, implant, injection, IUD, (Tables 11 and 12)

BEHAVIORAL OUTCOME	BIRTH SPACING WITHOUT MODERN CONTRACEPTIVES	BIRTH SPACING WITH MODERN CONTRACEPTIVES
Knowledge-related factors affecting outcome	• Lack of knowledge and misconceptions about breastfeeding • Lack of knowledge of lactational amenorrhea method as an option • Lack of knowledge of optimal duration of spacing	• Lack of knowledge of full range of methods, and benefits and risks of each method • Rumors and misinformation about contraceptive side effects, including effects on fertility • Lack of knowledge of optimal duration of spacing
Groups most influential to men regarding behavioral outcome	• Healthcare providers, family and friends (Table 7) • Family and friends especially influential for separation methods	• Healthcare providers, family and friends (Table 7) • Healthcare providers especially influential for contraceptive choice
Social norms influencing behavioral outcomes	• Period of postpartum abstinence should be observed	• Women should not start contraceptives without full knowledge and permission of the man
Factors favoring compliance with social norms	• Birth spacing and postpartum abstinence considered better for health and nutrition of mother and baby	• Birth spacing considered better for health and nutrition of mother and baby
Factors favoring non-compliance with social norms	• Norm favoring postpartum abstinence thought to favor infidelity	• Covert contraceptive use raises concerns about infidelity

Some recommendations specific to birth spacing and family planning more generally are listed in the next table.

Table 16. *Recommendations for building support of men for birth spacing*

BEHAVIORAL OUTCOME	BIRTH SPACING WITHOUT MODERN CONTRACEPTIVES	BIRTH SPACING WITH MODERN CONTRACEPTIVES
Recommendations specific to behavioral outcome	• Address the strengths and weaknesses of non-contraceptive methods of birth spacing, especially in the curriculum for rural areas • Include traditional healers in training on family planning, inform them and use them as actors in the promotion of non-contraceptive and contraceptive methods in their respective communities; • Promote exclusive breastfeeding, address misconceptions about it, and explain its potential role in birth spacing in training curriculum and campaigns	• Increase awareness of healthcare providers of their social influence and ability to promote change in social norms, and build their skills in behavior change communication • Training of medical and non-medical providers in family planning / modern contraceptives and communication for social and behavior change will need to be intensified; • Include module on managing rumors and misinformation in the family planning training curriculum and introduce clinical and community providers to this approach;

BEHAVIORAL OUTCOME	BIRTH SPACING WITHOUT MODERN CONTRACEPTIVES	BIRTH SPACING WITH MODERN CONTRACEPTIVES
Recommendations relevant to both outcomes	• Study ways and means of adapting communication techniques that do not threaten men, or lead them to believe that their power and authority are being undermined, and respecting the aspects of gender in the current context; • Popularize the law on Sexual and Reproductive Health in the country to facilitate compliance with it among local populations, and build self-efficacy of health care providers to enforce the law; • Revitalize community-based organizations (CAC, local associations, clubs, etc.) and involve them in promoting family planning; • Develop a strategy for social and behavior change targeting men and their influencers made up of religious leaders, nurses, and their peers to encourage them to be involved in family planning; • Design a multi-stakeholder awareness campaign to promote family planning nationwide.	

Implications for promotion of limiting family size

Conflicting social norms and community values, one promoting spaced births and the other encouraging large families, complicates the pathway to achieving these behavioral outcomes. The next table summarizes factors influencing support of men for limiting family size.

Table 17. *Factors influencing support of men for limiting family size*

BEHAVIORAL OUTCOME	LIMITING FAMILY SIZE
Knowledge-related factors affecting outcome	• Limited knowledge of benefits of limiting family size • Limited knowledge and availability of permanent methods of contraception • Lack of awareness of elevated maternal and infant mortality in pregnancies occurring in women over 35 years of age
Groups most influential to men regarding behavioral outcome	• Religious leaders • Senior family members • [No role for healthcare providers identified in the data]
Social norms influencing behavioral outcomes	• Families should have as many children as God sends them • Families should "fill the world" with children
Factors favoring compliance with social norms	• Support of religious leaders for large families • Perception that religion supports large families
Factors favoring non-compliance with social norms	• Health problems of women that make further pregnancies dangerous to their health

The next table lists some recommendations for building support among men for limiting family size.

Table 18. *Recommendations for building support of men for limiting family size*

INFLUENTIAL GROUPS	LIMITING FAMILY SIZE
Religious leaders and senior family members	• Include religious and community leaders in training on family planning, inform them and use them as actors in the promotion of family planning, and limiting family size among older couples in their respective communities;
Healthcare providers	• Increase awareness of healthcare providers of their social influence and ability to promote change in social norms especially those related to health and nutrition of women and children • Training of medical and non-medical providers in permanent methods of contraceptive, and family planning needs of older couples; • Include module on risks to women and children from pregnancies in women over 35 years of age.

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Annex 1: Results from Phase 1 Questionnaire

Table 19. *Type of family member cited, by province (N=64)*

	FAMILY MEMBER CITED: % (N)									TOTAL
	FATHER	BROTHER	GRAND-MOTHER	GRAND-FATHER	AUNT	UNCLE	COUSIN	SISTER-IN-LAW	PARTNER	
Kasai Central	0	15.4% (4)	3.9% (1)	23.1% (6)	0	3.9% (1)	0	3.9% (1)	50% (13)	**100% (26)**
Lualaba	15.4% (4)	19.2% (5)	0	0	7.7% (2)	3.9% (1)	0	0	53.9% (14)	**100% (26)**
Sankuru	41.7% (5)	50% (6)	0	0	0	0	8.3% (1)	0	0	**100% (12)**
Total	**14.1% (9)**	**23.4% (15)**	**1.6% (1)**	**9.4% (6)**	**3.1% (2)**	**3.1% (2)**	**1.6% (1)**	**1.6% (1)**	**42.2% (27)**	

Table 20 . *Type of family member cited, by urban/rural geography (N=64)*

	FAMILY MEMBER CITED: % (N)									TOTAL
	FATHER	BROTHER	GRAND-MOTHER	GRAND-FATHER	AUNT	UNCLE	COUSIN	SISTER-IN-LAW	PARTNER	
Urban	12.5% (4)	21.9% (7)	0	9.4% (3)	0	3.1% (1)	3.1% (1)	0	50% (16)	**100% (32)**
Rural	15.6% (5)	25% (8)	3.1% (1)	9.4% (3)	6.3% (2)	3.1% (1)	0	3.1% (1)	34.4% (11)	**100% (32)**
Total	**14.1% (9)**	**23.4% (15)**	**1.6% (1)**	**9.4% (6)**	**3.1% (2)**	**3.1% (2)**	**1.6% (1)**	**1.6% (1)**	**42.2% (27)**	

Table 21. *Type of peer group cited, by province (N=76)*

	PEER GROUP CITED: % (N)					TOTAL
	FRIEND FROM A RELIGIOUS GROUP	FRIEND FROM A COMMUNITY GROUP	FRIEND FROM A PROFESSIONAL GROUP	NEIGHBOR	OTHER	
Kasai Central	0	28.6% (4)	35.7% (5)	35.7% (5)	0	**100% (14)**
Lualaba	5.3% (2)	52.6% (20)	34.2% (13)	5.3% (2)	2.6% (1)	**100% (38)**
Sankuru	41.7% (10)	25% (6)	25% (6)	8.3% (2)	0	**100% (24)**
Total	**15.8% (12)**	**39.5% (30)**	**31.6% (24)**	**11.8% (9)**	**1.3% (1)**	

Table 22. *Type of peer group cited, by urban/rural geography (N=76)*

	PEER GROUP CITED: % (N)					TOTAL
	FRIEND FROM A RELIGIOUS GROUP	FRIEND FROM A COMMUNITY GROUP	FRIEND FROM A PROFESSIONAL GROUP	NEIGHBOR	OTHER	
Urban	14.9% (7)	40.4% (19)	34% (16)	8.5% (4)	2.1% (1)	**100% (47)**
Rural	17.2% (2)	37.9% (20)	27.6% (13)	17.2% (2)	0	**100% (29)**
Total	**15.8% (12)**	**39.5% (30)**	**31.6% (24)**	**11.8% (9)**	**1.3% (1)**	

Table 23. *Type of provider cited, by province (N=149)*

	PROVIDER CITED: % (N)						TOTAL
	DOCTOR	NURSE	MIDWIFE	PHARMA-CIST	RECO	OTHER	
Kasai Central	34.6% (19)	32.7% (18)	10.9% (6)	3.6% (2)	18.2% (10)	0	**100% (55)**
Lualaba	63% (17)	33.3% (9)	0	0	0	3.7% (1)	**100% (27)**
Sankuru	13.4% (9)	74.6% (50)	7.5% (5)	0	4.5% (3)	0	**100% (67)**
Total	**30.2% (45)**	**51.7% (77)**	**7.4% (11)**	**1.3% (2)**	**8.7% (13)**	**0.7% (1)**	

Table 24. *Type of provider cited, by urban/rural geography (N=149)*

	PROVIDER CITED: % (N)						TOTAL
	DOCTOR	NURSE	MIDWIFE	PHARMACIST	RECO	OTHER	
Urban	46.6% (34)	37% (27)	9.6% (7)	1.4% (1)	5.5% (4)	0	**100% (73)**
Rural	14.5% (11)	65.8% (50)	5.3% (4)	1.3% (1)	11.8% (9)	1.3% (1)	**100% (76)**
Total	**30.2% (45)**	**51.7% (77)**	**7.4% (11)**	**1.3% (2)**	**8.7% (13)**	**0.7% (1)**	

Annex 2: Brief Interview Guide

"My Social Network" Activity

Introduction:

Today I will be asking you about your conversations related to family planning. Family planning methods, or contraception, are methods you and your partner may use to delay or avoid pregnancy. These can be natural methods such as withdrawal or avoiding sex when a woman is most fertile, methods that you can get at a pharmacy such as condoms or pills, and methods that you need to get from a health facility such as implants, IUDs, or sterilization.

What I am interested in today is whether and with whom you talk to about family planning. I am also interested in learning whose opinions are important to you when you think about family planning.

There are no right or wrong answers to the questions I will ask you, so please share your thoughts with me as completely and honestly as possible. OK, let's get started with our conversation.

Data collector to complete silently:

1. Name of data collector: ____________________
2. Date of interview:
   c. Day: ___ ___
   d. Month: ___ ___
   e. Year: ___ ___ ___ ___
3. Province
   a. Sankuru
   b. Lualaba
   c. Kasai Central

4. Health area
    a. Area 1 (To be specified)
    b. Area 2 (To be specified)
    c. Area 3 (To be specified)
    d. Area 4 (To be specified)
5. Type of participant
    a. Married / Cohabitating man, ages 15-39
    b. Unmarried man, ages 18-39
6. Participant ID number ___ - ___ - ___ ___

Data collector to ask participant out loud:

7. What is your age? ___ ___
8. Are you currently living in the same house as a romantic partner or spouse? When I say living in the same house, I mean you usually sleep in the same house as a romantic partner or spouse four or more days per week.
    a. Yes
    b. No
    c. No answer
9. REFERENCE GROUP - DISCUSSING FP

    When discussing family planning methods – from questions about what they are, to where to get them, how to use them, and if you or your partner should use it – with whom do you feel comfortable discussing these topics? Even if you have not discussed this topic before, pick who you feel you *would* talk to for information and advice.

(Read options aloud, select one.)

Family member	1	→ Go to 10
Friend	2	→ Go to 16
Local leader	3	→ Go to 18
Health care worker	4	→ Go to 19
(Do not read aloud) Don't know/refuse to answer	5	→ End survey, consider incomplete

10. FAMILY MEMBER

    With what type of family member do you feel comfortable discussing these topics? (Do not read options aloud. Select first person participant identifies. If participant responds with broader category such as "parent," probe for specific family member such as mother or father.)

<table>
<tr><td>Mother</td><td>1</td><td rowspan="2">→ Go to 21</td></tr>
<tr><td>Father</td><td>2</td></tr>
<tr><td>Brother</td><td>3</td><td rowspan="2">→ Go to 11</td></tr>
<tr><td>Sister</td><td>4</td></tr>
<tr><td>Grandmother</td><td>5</td><td rowspan="2">→ Go to 12</td></tr>
<tr><td>Grandfather</td><td>6</td></tr>
<tr><td>Aunt</td><td>7</td><td rowspan="2">→ Go to 13</td></tr>
<tr><td>Uncle</td><td>8</td></tr>
<tr><td>Cousin</td><td>9</td><td>→ Go to 14</td></tr>
</table>

Mother-in-law	10	→ Go to 21
Father-in-law	11	
Brother-in-law	12	→ Go to 15
Sister-in-law	13	
Spouse/partner	14	→ Go to 21
(Do not read aloud) Other relative	15	10_a: Specify: ____________________ → Go to 21

BROTHER / SISTER

Is this person older or younger than you?

Older	1	→ Go to 21
Younger	2	
(Do not read aloud) Same age; twin	3	

GRANDMOTHER/GRANDFATHER

Is this person on your mother's side or father's side?

Mother's side	1	→ Go to 21
Father's side	2	

AUNT/UNCLE

Is this person on your mother's side or father's side?

Mother's side	1	
Father's side	2	

Is this person a sibling, cousin, or other relation to your parent?

Sibling	1	
Cousin	2	
Other	3	

Is this person older or younger than the parent they are related to?

Older	1	→ Go to 21
Younger	2	
(Do not read aloud) Same age; twin	3	

COUSIN

Is this person on your mother's side or father's side?

Mother's side	1	
Father's side	2	

Is this person older, the same age, or younger than you?

Older	1	
Same age	2	
Younger	3	

Is this person male or female?

Male	1	→ Go to 21
Female	2	

BROTHER-IN-LAW/SISTER-IN-LAW

Is this person older or younger than your partner?

Older	1	→ Go to 21
Younger	2	
(Do not read aloud) Same age; twin	3	

FRIEND

With what type of friend do you feel comfortable discussing these topics? (Read options aloud. Select one.)

Friend from religious group	1	→ Go to 17
Friend from community group	2	
Friend from professional group	3	
Neighbor	4	
(Do not read aloud) Other	5	16_a: Specify: ____________________ → Go to 17

FRIEND - DETAIL

Is this person older, about the same age, or younger than you?

Older	1	
About the same age	2	
Younger	3	

Is this person male or female?

Male	1	→ Go to 21
Female	2	

LOCAL LEADER

With what type of local leader do you feel comfortable discussing these topics? (Read options aloud. Select one.)

Professional group leader (e.g., agricultural association)	1	→ Go to 21
Religious group leader	2	
(Do not read aloud) Other type of group leader	3	18_a: Specify: ____________________ → Go to 21

HEALTH CARE WORKER

With what cadre of health worker do you feel comfortable discussing these topics? (Read options aloud. Select one.)

Doctor	1	→ Go to 20
Nurse/*Infirmiere or Infirmiere Titulaire*	2	
Midwife/*Sage femme*	3	
Pharmacist	4	
Community health worker/*Relais Communautaire (ReCo)*	5	→ Go to 21
(Do not read aloud) Other type of health care worker	6	19_a: Specify: ___________________→ Go to 21

DOCTOR / NURSE / MIDWIFE / PHARMACIST

Does this health care worker work in a public, religious/confessional, private, or other type of health facility?

Public	1	
Religious/confessional	2	
Private	3	
Other type of facility	4	
(Do not read aloud) Do not know	5	

ADHERENCE TO REFERENCE GROUP

How likely would you say you are to listen to this person's advice about family planning? (Read options aloud. Select one.)

Not at all likely	1	
Somewhat unlikely	2	
Neither unlikely nor likely	3	
Somewhat likely	4	
Very likely	5	
(Do not read aloud) No answer/Refuse	9	

Conclusion (read to participants):

Thank you for your time, we really appreciate your willingness to share this information.

Do you have any questions for me before we end?

Annex 3: In-Depth Interview Guide

<table>
<tr><td colspan="2">Province:

a. Sankuru
b. Lualaba
c. Kasai Central</td><td>Health area:</td></tr>
<tr><td>Data collector:</td><td>Participant ID number:

___ - ___ - ___ ___</td><td>Date:

_ _/_ _/ _ _ _ _

Day / Month / Year</td></tr>
<tr><td colspan="3">Behavior of Interest:

Men’s involvement in about FP decision-making</td></tr>
</table>

Introduction to participants:

Today I will be asking you about your conversations related to family planning. What I am interested in today is hearing more about how you think and talk about family planning, and how others close to you talk and think about that topic. We will start with some general questions, so I can get to know you more. After that, I will present you with a scenario - short story that is about people making family planning decisions. As we go through the story, I will stop to ask you about your thoughts on the situation and actions of the characters. There are no right or wrong answers to the questions I will ask you, so please share your thoughts with me as completely and honestly as possible. OK, let’s get started.

PART 1: [25 min]

1. Tell me about your immediate family. Who lives in your household?

   PROBE: Do you live with a wife or partner? Do you have multiple wives or romantic partners? How long have you been married or living with your wife(s) or romantic partner(s)? Who else lives in the house?
   PROBE: Do you have any child(ren)? How many children? What are their ages?

2. What do you know about family planning? (e.g., what is it for, what methods, who uses it)
   Thank you for those thoughts. When we talk about family planning methods, or contraception, I will be referring to any methods you and your partner may use to delay or avoid pregnancy. These can be natural methods such as withdrawal or avoiding sex when a woman is most fertile, methods that you can get at a pharmacy such as condoms or pills, and methods that you need to get from a health facility such as implants, IUDs, or sterilization.

3. In your opinion, who is family planning for?
   PROBE: what type of men or women use family planning?

4. Have you ever tried to get more information about family planning? If so, from where or from whom?

5. As a man, what do you think your role is with respect to family planning?

6. Do you think people in your community expect you to be involved in any of this FP process? What parts of the process do others expect you to be involved in? What parts of the process do others expect you would NOT be involved in? PROBE: information-gathering, starting a conversation with a partner about FP, decision-making about using FP, going to the pharmacy or health facility with their partner to obtain a method, or men using a FP method themselves)? What makes you think that they do or do not expect you to be involved?

7. How do men in your community commonly talk about family planning?

   PROBE: What topics related to FP do men talk about? What do men think about using FP? For whom is it acceptable and for whom is it not acceptable?

   PROBE: What do men think or say about…

a) Their male peers initiating a conversation with their partner about FP?

b) Men who are involved in family planning decision-making?

c) Men who accompany a partner to obtain a FP method?

d) Men who use a method of family planning themselves?

PART 2 (Read aloud to participant):

Thank you for answering those questions. Now, I will share a story that is about the experience of a husband named Mbuyi and his wife named Safi as they make decisions about using family planning.

SECTION 1 [10 min]

Safi is a 21-year-old who sells vegetables and seeds at the market. She lives with her husband, Mbuyi, a 26-year-old who works in the mines nearby. They have been married for 3 years and they have 2 daughters. The first daughter is 2 years old and the second is 6 weeks old. Recently, Mbuyi asked Safi when they should start trying to have a third child. Mbuyi said he would like to have another child, and Safi agreed but said she has heard it is best for her health and the health of their infant if she waits a few years before trying to get pregnant again. With this information, Mbuyi and Safi agreed that they should use some method to delay having another child and that they should find out about their options from the health center. Since Mbuyi must work when the health center is open, Safi visits the health center on her own to ask for more information.

1. What do you think of Mbuyi initiating the conversation with Safi about how much time they may want to wait before their next child? Is that something that would typically happen? Why or why not?
2. What do you think people in your community would expect for how long Mbuyi and Safi should wait before having their third child? Do you think different people would have different expectations – in what way?

SECTION 2 [10 min]

At the health center Safi talks to a midwife who describes several methods of family planning that can be used to delay having a child and suggests Safi try an implant or IUD. Safi is interested in adopting one of these methods but is not sure if Mbuyi would have a preference about the method to select. So, Safi goes home and discusses what she has learned.

3. What do you think about Safi going to the health center without Mbuyi to find out information about FP? Is this something that typically happens in your community?

a. What would people in your community think or say about a man who accompanies his partner/wife to the health center to learn about family planning?

b. What would people in your community think or say about a man who is eager to learn more about family planning options available for child spacing?

4. What do you think about Safi discussing which method to adopt with Mbuyi before selecting one? Is this something that would typically happen in your community?

a. What would you think of Safi if she did not discuss which method to select with Mbuyi, but instead decided for herself and got the method during that health center visit?

PROBE: Would that be an acceptable way to act? Why or why not?

SECTION 3 [15 min]

Safi shares what she learned about child spacing methods with Mbuyi a few days later. In the meantime, Mbuyi has been thinking to himself and talking with other people about when to have another child and whether to adopt a child spacing method. Mbuyi is now leaning towards having a third child sooner, rather than adopting a family planning method to delay. Mbuyi doesn't explain his reasons to Safi, but tells her that they should no longer pursue using a family planning method to delay their next pregnancy.

5. Do you think most people in your community would expect men to act the way that Mbuyi did in this situation? Why or why not?

   PROBE: Which type of people in your community would expect Mbuyi to act like this? Which type of people would expect Mbuyi to have acted differently? In what different way would they have expected Mbuyi to act?

6. What do you think could be influencing Mbuyi to change his mind about delaying pregnancy and adopting a child spacing method?
7. Who do you think Mbuyi was talking to that may have contributed to changing his mind about when to have an-

other child? (e.g., sister, father, mother, mother-in-law, religious leader, co-worker)

a. Why might this person suggest having another child without delay?

b. Who are the people who can most influence a couple's decisions about whether to use family planning?

8. Understanding that Mbuyi is no longer supportive of using a child spacing method, what do you think might happen next for this couple?

PROBE: Do you think Mbuyi and Safi would discuss this decision further?

If so, is it typical for husbands and wives to discuss the time they want between children, and how to ensure space between pregnancies? Who initiates those discussions?

If not, what action do you think Mbuyi and Safi would take next, and why?

a. If Mbuyi and Safi do discuss this decision further, do you think Mbuyi ought to explain to Safi why he has changed his opinion? Why or why not? What types of things do you think Mbuyi might say to Safi about his reasoning?

b. How do you think Mbuyi and Safi would be expected to decide what to do in this situation, given their differing opinions? In particular, what would community members expect Mbuyi to say or do in this situation?

i. Who sets or enforces that expectation for a couple? Particularly, who sets or enforces that expectation for the role of the husband?

ii. What happens if a couple does not act according to that expectation? For example, if the expectation is that Mbuyi would be the one to make the ultimate decision for the couple, what would people in your community think or say about a couple who acted differently?

If further probe needed: Imagine a couple where the husband listened to and accepted the wife's desire to delay, talked with her about the methods she had been recommended, and listened to her preferences for which method to adopt. What would people in your community think or say about that man?

SECTION 4 [10 min]

After discussing their opinions further, Mbuyi and Safi agree that delaying another child for 2 years would be the best decision for their family. They discuss the methods that were recommended by the midwife and like how an implant is a reversible method that can last for 2-5 years and is placed in a woman's arm. Safi says she will go the health center next week to get an implant inserted. The next day Mbuyi tells his elder sister about the conversation he had with Safi and their decision to use an implant. His sister scolds him, "Mbuyi, children are a blessing from God. Safi should not adopt this family planning method. You must have your next child when God wants." Now Mbuyi is not sure about what to say to Safi, or what they should do. He still thinks that Safi and his decision to delay having another child is best for their family, but he also thinks his elder sister's opinion about using family planning is important.

9. Do you think this is a typical situation that might happen in your community? Why or why not?

10. What do you think people in your community would think or say about the elder sister's response?

11. What do you think Mbuyi and Safi should do, given his sister's opposition to their use of family planning?

a. How do you think the elder sister's comments would affect Mbuyi's thinking about the decision he and his wife made together?

CONCLUSION: [5 min]

12. Thank you for your comments about this scenario. After hearing the scenario, what do you think is most important for you, as a man, to consider when thinking about family planning? Why is that factor the most important for you?

13. Do you have any final thoughts this story that you would like to share with me?

Thank you for your time. We really appreciate your willingness to share your ideas.

Do you have any questions for me before we end?

Annex 4: Focus Group Discussion Guide

<table>
<tr><td>Province:
d. Sankuru
e. Lualaba
f. Kasai Central</td><td colspan="2">Health area name:</td></tr>
<tr><td>Data collector 1:
Data collector 2:
Data collector 3:</td><td>Date:
_ _/_ _/_ _ _ _
Day / Month / Year</td><td>FGD Start time:
_00:00 h___</td></tr>
<tr><td>Behavior of Interest:
Men’s communication about FP/contraceptive use</td><td>Reference Group:
______________</td><td>Group Number:
1 or 2</td></tr>
</table>

Start audio recording: Note the date, time, reference group and number.

Introduction to participants:

Today we will be asking you about your conversations related to family planning. What we are interested in today is hearing more about how you think and talk about family planning, especially when you are speaking with and giving advice to men in your lives.

We will start with some general questions, so we can get to know you more. After that, we will break into smaller groups to do an activity where you have a conversation, then share what you talked about with the full group. Finally, I will present the whole group with a scenario – a short story that is about people making family planning decisions. As we go through the story, I will stop to ask you about your thoughts on the scenario.

There are no right or wrong answers to the questions we will discuss today, so please share your thoughts with me and with each other as completely and honestly as possible. I also ask that you do not share what we discuss in this group with others afterwards – what we talk about here can remain between us. OK, let’s get started.

PART 1: [20 min]

1. In your opinion, how much do men in your community know about family planning methods?
   PROBE: a little vs. a lot, what types of information, what methods are they familiar with

2. Where do they learn this information?
   PROBE: from whom: friends, relatives – which types of relatives, community leaders, religious leaders, health workers – what types of health workers, etc.
   PROBE: when: during casual discussions/free time, during holidays, during community meetings, during sermons or religious services, in healthcare consultations, etc.

3. Do men ever discuss family planning and contraceptives with their friends or men who are important to them? What types of friends, or who are the men they might discuss FP with?

4. What might be said in a conversation between two men about family planning and contraceptives?

PART 2a: [20 min]

Thank you for sharing your thoughts. Now we are going to do an activity called “The 5 Whys.” We will split into pairs or small groups, and I will give each group two questions to discuss with one of our study team members. You will have 10 minutes to discuss the first question and another 10 minutes to discuss the second question.

A study team member will start by asking the group the first question. The people in the group should respond with their opinions. If there are multiple reasons, the group should decide together on the response that they think is the primary, most important reason. Then the study team member will ask group *why this reason is so*, and the group will respond again. The study team member will keep asking *why* for each answer from the group until they have asked why five times. In this way we are digging for the *deepest reasons* behind men’s roles in family planning decision-making. We want to think deeply about why things in this community are the way that they are. In this activity, think of a tree. The question we start with is what you see of the tree above the ground. But we will be asking why, over and over. With each time we ask why we are trying to go down to a deeper root of the tree and uncover where

it came from.

Pause audio recording for full group.

Instructions for the data collectors:

One data collector should facilitate each pair and should have a piece of paper with the tables on the following page, to take notes for the questions his/her group discusses.

Start an audio recording in each small group. Note the date, time, reference group and number, and small group number (1-3).

Lead a 5 whys exercise with the first question and probe through 5 levels of why, discussing for 10 minutes or until the group has exhausted this conversation. Write down the group consensus for a single response to why at each level of probing using the sheet that follows. Then, repeat the process with the second. It may be possible that the reasons why are the same for the first and second question, and that is OK.

Group 1 will discuss the questions:

1. Some men do not talk to their wives or partners about how many children they want to have in total for their family. Why is that?
2. When a couple has decided they will use FP, some men do not allow their wife or partner to freely or independently choose what FP method to adopt. Why is that?

Group 2 will discuss the questions:

3. Some men do not talk to their wives or partners about how much time they want to wait in between having children. Why is that?
4. When a couple has decided they will use FP, some men do not allow their wife or partner to freely or independently choose what FP method to adopt. Why is that?

Group 3 will discuss the questions:

5. Some men are not the one to *initiate* conversations about FP with their wives or partners. Why is that?
6. When a couple has decided they will use FP, some men do not allow their wife or partner to freely or independently choose what FP method to adopt. Why is that?

Once the small group discussion is finished, stop the audio recording.

PART 2a: NOTES

Group Number: ______

Question 1	Response
The study team member will record the answers from your group on a piece of paper and will also audio record your small group's discussion. We will repeat this five why process for two questions in each group.	
Question (Underline the question your group discussed): Group 1: Some men do not talk to their wives or partners about how many children they want to have in total for their family. Why is that? **Group 2:** Some men do not talk to their wives or partners about how much time they want to wait in between having children. Why is that? **Group 3:** Some men are not the one to *initiate* conversations about FP with their wives or partners. Why is that?	Because:
Why is that the case? / Why do they think that would happen?	Because:
Why is that the case?	Because:
Why is that the case?	Because:
Why is that the case?	Because:

Question 2	**Response**
When a couple has decided they will use FP, some men do not allow their wife or partner to freely or independently choose what FP method to adopt. Why is that?	Because:
Why is that the case?	Because:

Why is that the case?	Because:
Why is that the case?	Because:
Why is that the case?	Because:

PART 2b: [20 min]

Restart audio recording for full group. Note the date, time, reference group and number, and that this is Part 2 of the FGD.

Study team members: Use the flipchart to write responses from each group for Question 2.

Main discussion leader: Thank you for sharing your ideas in the small groups. All the groups discussed the question "When a couple has decided they will do something to delay or avoid having another child, some men do not allow their wife or partner to freely or independently choose what FP method to adopt. Why is that?"

1. First, I want to know if you think men should allow their wife or partner to freely or independently choose what FP method to adopt, once they have decided that they will do something to delay or avoid having another child? Why or why not?

For the rest of this discussion, let's say we want men to support their partners to choose a FP method, even on their own. The study team members have written here the reasons you gave for why this does not happen sometimes.

Read through each group's 5 reasons. After going through all the groups, speak aloud as you group together the reasons that are similar across groups.

2. Are there any other reasons that were mentioned by more roup, that seem the same?

When a couple has decided they will do something to delay or avoid having another child, some men do not allow their wife or partner to freely or independently choose what FP method to adopt. Why is that?	**ResponGroup**
GROUP 1	Because (1): Because (2): Because (3): Because (4): Because (5)
GROUP 2	Because (1): Because (2): Because (3): Because (4): Because (5):
GROUP 3	Because (1): Because (2): Because (3): Because (4): Because (5):

3. Now that we have a list of reasons why some men do not allow their wife or partner to freely or independently choose what FP method to adopt…

a. Which of these reasons, beliefs, or expectations for what would happen is most important to change in your community to allow women to freely or independently choose what FP method to adopt? Why do you think that one is the most important to change? Remember that we are approaching this conversation from a position of wanting men to support their partners to choose a FP method freely and independently.

i. Do others agree or disagree?

ii. Who would we have to involve to change that reason, belief or expectation in your community?

iii. How does that reason, belief or expectation affect the way men communicate with their wives or partners about FP?

b. Does anyone think another reason is most important to change? Why that reason?

i. Who would we have to involve to change that reason, belief or expectation in your community?

ii. How does that reason, belief or expectation affect the way men communicate with their wives or partners about FP?

PART 3 (Read aloud to participants): [30 min]

This story is about the experiences of Safi, a wife, Mbuyi, her husband, and their decisions around family planning.

Safi is a 21-year-old who sells vegetables and seeds at the market. She lives with her husband, Mbuyi, a 26-year-old who works in the mines nearby. They have been married for 3 years and they have 2 daughters. The first daughter is 2 years old and the second is 6 weeks old. After her second daughter was born, Safi went for her 6-week postnatal visit at the local health center. At the visit, she was reminded to consider delaying having another child for 2 years and she was given counseling on different methods of family planning that can be used for child spacing.

Safi went home and told her husband about what she heard and said she would like to consider ways to delay having another child. Mbuyi was against the idea that they use a child spacing method.

Questions:

1. Do you think this is a typical situation that might happen in your community? Why or why not?
2. What are some reasons that Mbuyi might be against child spacing methods?
3. What may be some of the reasons that Safi wants to pursue child spacing methods?
4. Understanding that Mbuyi was not supportive of using child spacing methods, what might happen next between Mbuyi and Safi?
5. If Mbuyi and Safi discussed this further, do you think they might involve any other people in the conversation to help them make decisions?
   a. If so, who would that be?
   b. Why would they choose to either involve or not involve this person when deciding about family planning?
   c. What kind of advice do you think they may receive from this person?
   d. What do you think would happen to Mbuyi and Safi if they followed this person's advice?
   e. What do you think would happen to Mbuyi and Safi if they decided <u>not to</u> follow this person's advice?
6. Do you have any final thoughts about this story that you would like to share?

Conclusion:

Thank you for your discussion of that story, and for your time. We really appreciate your willingness to share your ideas. Do you have any questions for me before we end?