Analyzing Supply and Demand for Family Planning in ASSP–supported Health Zones in the DRC: a Case Study

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11 July 2016

ACKNOWLEDGMENTS

The team from the Tulane School Public Health and Tropical Medicine (SPHTM) wishes to thank the United Kingdom Department for International Development (DFID) for its support of the ASSP project and the work completed under the Operations Research and Impact Evaluation (ORIE) component (IMA-DFID/ASSP102012-1/Tulane). We appreciate the guidance received from Daniel Carter, Sarah Goldsmith, Lizz Yocum, and Gemma Gargent.

Tulane also acknowledges the productive collaboration with IMA World Health, represented in the DRC by Drs. Larry Sthreshley and Mano Ntayingi; and with Pathfinder International, represented by Dr. Marie Claude Mbuyi. The in-depth discussions over ways to improve the measurement and calculate couple-years of protection (CYP) targets greatly assisted the authors in finalizing this work. Dr. Emily Sonneveldt of Avenir Health provided expert consultation on the CYP targets in Chapter VIII.

The authors wish to thank members of Mr. Mbadu Muanda's team for data collection, analysis, and preparation of a preliminary report in French in relation to the qualitative findings for this study (presented in Chapters IX and X). In particular, we are grateful to Parfait Gahungu and Bertin Kanumbi Tshama. Others who assisted in the qualitative research include Rose Kavugho, Mbongo Pasi Maguy, Judith Buhendwa, Sylvie Mbuaya, and Ndudi Baby.

In the Tulane International LLC/Kinshasa office, Dr. Paul Lusamba provided important input into the technical aspects of the study design. Dr. Arsène Binanga assisted in introducing the corrections in the national CYP factors to those responsible for the National Health Information System (SNIS). Joyce Visi assisted with the financial management of the project; Liliane Biola and Cathy Putela provided administrative support.

The authors would also like to thank the staff from various teams who participated in the interviews for this case study, including Pathfinder International, the ASSP Implementing Partners, the MOH officials at the central and provincial levels, and the teams in selected health zones cited in the report. Without their support the data collection would not have been possible.

From the Tulane SPHTM offices in New Orleans, we thank Dr. David Hotchkiss and his research assistants Janna Wisniewski and Rieza Soeleman for their work on the ASSP baseline survey, which provided the data used in Chapters V and VI. We are grateful to Dr. Julie Hernandez for the production of the map that appears as Figure 1. Alexandra Spector and Maria Herdoiza assisted with financial management of the project. Ellie Arbeit and Olivia Barnard served as research assistants.

EXECUTIVE SUMMARY

Introduction: This report presents a case study of family planning in the context of IMA World Health's ASSP Project (Accès aux Soins de Santé Primaires) in the Democratic Republic of the Congo (DRC). The primary objective of ASSP is to improve reproductive, maternal, neonatal, and child health (RMNCH) through a broad range of interventions, including family planning which is a priority area for this project. Specifically, the family planning (FP) component of ASSP aims to (1) reinforce RMNCH services in ASSP supported health zones, (2) generate demand for high quality RMNCH services, (3) improve the quality of services, (4) ensure sustainability of service delivery, and (5) ensure women and men, youth and adolescents, are informed about their reproductive health (RH) rights. In order to understand how the FP component has performed to date, this case study examines the level of contraceptive use at the start of the program, facility-based data on readiness to provide services, outputs generated to date, and attitudes of stakeholders (including community members) toward the project. In addition, it makes recommendations for actions to increase modern contraceptive prevalence rate (mCPR) by the end of the project in 2018.

Methodology. This case study used a mix of quantitative and qualitative research methods, summarized in the following chart.

Research objectives	Sources of data	Number of subjects interviewed
Review of previous large-scale integrated health projects and other projects designed to increase mCPR in rural areas of the DRC	Literature review, including evaluation reports of these projects	
Policy environment for family planning in the DRC (with implications for ASSP)	Literature review	
Contraceptive use dynamics in the ASSP-supported health zone (HZ) at the start of the project	ASSP baseline household survey (with comparisons to the Demographic and Health Survey [DHS] Survey 2013-2014)	Secondary analysis of ASSP baseline survey among 2,108 women
Readiness of health facilities to provide FP services	ASSP baseline facility-based survey	Secondary analysis of ASSP baseline survey in 105 facilities
Inputs for the FP component of the ASSP project	ASSP project documents prepared by Pathfinder International	
Family planning performance as measured by CYP and new acceptors	Service statistics provided by ASSP to Pathfinder for use in quarterly reports	
Opinions and perceptions of Ministry of Health (MOH) and project personnel in relation to the FP component of the project	Key informant interviews	26 in total (see Table 3 for number per category)
Attitudes of men, women, and young people toward family planning in the communities served by the ASSP project	Focus group discussions	432 participants in a total of 36 focus groups

Results. The key results by objective are as follows:

1. **Present the context for family planning in an integrated health services project in the DRC**

ASSP is the latest in this series of large-scale integrated health projects in the DRC. Although similar in some respects to the predecessor project Access to Healthcare (ATH), and the concurrent USAID-funded Projet de Santé Intégré (PROSANI) project, ASSP has given particular emphasis to family planning. Moreover, it is the first in the long tradition of integrated health projects to conduct an impact assessment of the project, including the family planning component.

Currently there is strong political support for family planning at both the central and provincial levels. From 2012 to present, the DRC government has made substantial progress to prioritize family planning, including increasing government funding for FP, adding FP to the government's list of elements to accelerate the achievement of the Millennium Development Goals and launching a National Strategic Plan for Family Planning. Qualitative interviews conducted at both the national and provincial levels confirm the government's support for family planning in the DRC.

2. Examine contraceptive use dynamics in the ASSP-supported HZs at the start of the project (population-based data from the baseline survey)

The baseline study conducted in 2014 in three sampling domains (generalizable to the ASSP-supported health zones) provided important data on this population at the time of the study. In this largely rural population, less than 5% of women have completed high school. By age 45-49, women in this population have had an average of 5.3 children.

Over 90% of women of reproductive age have heard of at least one method for preventing pregnancy. At the start of the project, 18.2% of women married or in union used some means of preventing pregnancy: 12.5% a traditional method and 5.7% a modern method. More than half of all modern users relied on male condoms, possibly because of limited access to a fuller range of contraceptives. Use of a modern method was higher among women who were in higher wealth quintiles and had at least some level of secondary education.

At the start of the project, unmet need was 21.2%, which by global standards is relatively high but not extreme. (By comparison, unmet need in Kinshasa is 31.3%). One could interpret this 21.2% to reflect a felt need on the part of many women in this population for a means of pregnancy prevention; yet a substantial number of women have no desire to delay their next pregnancy by at least two years. Only 3.3% of women had an unmet need for limiting.

One notable trend in the baseline data was higher knowledge of and use of modern contraceptive methods among women in Maniema/Tshopo as compared to the two other sampling areas in the ASSP baseline. One possible explanation is that women from Maniema/Tshopo were significantly higher on the wealth index than their counterparts in Equateur. Also, this higher mCPR most likely reflects the effects of previous family planning interventions in this area.

3. Assess readiness of health facilities in the ASSP-supported areas to provide FP services

During the first year of the project (which coincided with the baseline survey) the sampled facilities in ASSP areas were most likely to have condoms (50.0%) followed by oral contraceptives (35.6%). Family planning services were offered in the majority of health facilities surveyed (60.6%), although this varied greatly across sampling areas. Only 6.7% of health facilities had the four main methods: condoms, pills, IUDs, and implants. Consistently, Maniema/Tshopo had the highest percentage of health facilities (97.1%) offering FP services at the time of the baseline survey. Of these health facilities in Maniema/Tshopo, most (97.1%) offered these FP services for free.

4. Describe family planning inputs and activities implemented in relation to the government's Plan National de Dévéloppement Sanitaire (National Health Development Plan, PNDS) 2011-2015 priority pillars

Based on data provided by Pathfinder to the evaluation team, this report lists the inputs to this project over the following categories:

a. Service delivery
b. Human resources for health
c. Medications and specific inputs/infrastructure and equipment
d. Health information
e. Health financing
f. Governance

5. Analyze FP performance in ASSP-supported health zones based on output indicators

At the start of the project, DFID specified in its contract with IMA that if the project did not meet its CYP targets by Year 3, then IMA should reprogram its funding to improve performance in the area of family planning. To this end, Tulane used the service statistics provided by IMA/Pathfinder to independently confirm the numbers presented in the Pathfinder quarterly reports. Based on preliminary analysis of CYP, it proved necessary to correct the CYP conversion factors mandated by the SNIS. In addition, Tulane reviewed the CYP targets and recommended new targets that were linked to the expected increase in mCPR in ASSP-supported health zones. The new CYP targets were subsequently accepted by DFID, IMA, and Pathfinder.

The key findings from this analysis were as follows:

- **CYP**: the ASSP project exceeded its CYP target by 15% in 2014 and by 63% in 2015 (or by 48% for the two years combined).

- **Number of new acceptors**: over the first 11 quarters, the ASSP project exceeded its target by 27% (720,760 expected; 914,157 achieved). In the most recent quarter the project generated over twice as many new acceptors as targeted.

In short, the ASSP project has exceeded its targets in terms of performance as measured by these two indicators.

6. Assess attitudes of key stakeholders toward family planning in the ASSP project

Opinions and attitudes of MOH and ASSP project personnel toward FP in the ASSP project. Qualitative research (in-depth interviews) conducted with implementing partners revealed a strong partnership between IPs and IMA/Pathfinder. At the same time, the study identified areas for improvement such as more timely delivery of programmatic inputs, shorter time periods between training and post-training follow-ups, and the provision of educational materials to be used for demand creation. In interviews with the Médecins Chef de Zone de Santé (MCZ), all MCZs indicated that they were aware that FP was an ASSP project priority; however, many also cited frequent stock outs for contraceptive methods, especially for the highly popular contraceptive implant. Other problems identified by the MCZs and IPs included low motivation from healthcare providers due to the lack of financial incentives known as *primes*; insufficient personnel to provide FP services in health facilities, in particular female staff; providers enabling or hindering FP service provision based on personal beliefs; misinformation on the part of potential users; illiteracy of the rural population; and local customs and beliefs that discourage FP use.

Attitudes of men, women, and young people in the community toward family planning. Qualitative focus groups were carried out with men and women in six health zones (a "strong" and "weak" health zone in each sampling area), including users and non-users of family planning. A majority of women, users and non-users, were knowledgeable of modern FP methods. By contrast, men who did not use FP or whose wives did not use FP were less aware of modern methods. It is clear from the focus groups that men are important decision makers when it comes to using FP. Side effects, rumors about these methods, culture, religion, and lack of information were the main reasons given for non-use of FP methods by focus group participants. Many women who are currently not using a FP method stated that they would be open using FP in the future, provided their husband agrees.

In addition to men and women, focus groups were also conducted among unmarried young men and women ages 18 to 24. Although adults in the community discourage adolescent pre-marital sex, many unmarried youth engage in sexual relationships nevertheless. Female respondents were more likely than males to have heard of different contraceptive methods.

Additionally, youth noted that some providers pass judgment on young unmarried people seeking FP at facilities.

Limitations of the case study

This case study analyzed the FP achievement of ASSP for the project as a whole, rather than analyzing and comparing the situation across the health zones of different provinces. For example, Table 22 provides the CYP targets by sampling domain (corresponding to the health zones of specific provinces), but the analysis of achievement is performed for the project as a whole. In addition, Figure 6 shows CYP by quarter and by province; but it does not equate the CYP performance (which is a numerator measure) with the estimated denominator of the health zones supported by ASSP.

Similarly, the qualitative research was conducted in one "higher performing" health zone and one "lower performing" health zone in three provinces, to ensure that the findings reflected the gamut of FP experience across the ASSP health zones. However, the numbers were not sufficient to analyze the data by strong versus weak health zones. The major consequence of this limitation was the lack of specific information for mid-course corrections in the health zones in greatest need of improvement.

Conclusions and Recommendations

The FP component of the ASSP project will be by far the best documented and most thoroughly evaluated of any of the large-scale integrated health services projects implemented to date in the DRC. The baseline survey (both household- and facility-based) provides measures against which to evaluate the impact at the time of the endline survey.

Based on the output data (CYP and new acceptors), the project exceeded its targeted levels in 2014 and 2015 by 48%. However, the level of modern contraceptive use at the start of the project was very low (5.7%); the challenge is to increase this percentage to 11.1% by 2017. Focus groups among men and women in the community revealed barriers to contraceptive use that are common in sub-Saharan Africa: fear of side effects (particularly sterility or delayed return to fertility), lack of information/misconceptions regarding modern contraception, cultural norms favoring large families, the dominant role of men in family decision-making (including number of children), and non-availability of the desired method (stockouts). Yet these results also give program managers specific topics on which to focus future demand creation activities.

Based on analysis of these findings, the recommendations for mid-course corrections are as follows:

<u>Improve access to and quality of FP services:</u>

1) Improve mechanisms for the management of contraceptive logistics to

reduce/avoid stockouts of all contraceptive methods, but in particular the implant given its widespread popularity in the DRC;

2) Review the adequacy of staffing across all health zones (including willingness to deliver contraceptive methods in view of religious beliefs) and the opportunities to increase the percentage of female providers for FP;
3) Launch programmatic activity promptly after providers are trained; ensure that they receive necessary supplies and equipment at the time of training;
4) Train personnel to provide youth-targeted RH education and youth-friendly FP services at the community level;
5) Continue efforts to ensure regular payment of government workers (for all health services, including FP) as a means of improving motivation.

Increase demand for FP services:

1) Increase knowledge of modern contraception and availability of services through multiple communication channels (e.g., placing the newly revised family planning logo in health facilities to heighten awareness of service availability);
2) Develop communication strategies explicitly focusing on men, given their dominant position in family decision-making, including for family planning;
3) Encourage community leaders, community health workers, and service providers to promote greater male-female communication regarding number of children and contraceptive use;
4) Develop community level educational/motivational activities that address key barriers to FP use identified through this and other studies, including fear of side effects;
5) Recognize adolescents and young people as part of the target population for FP/RH activities in ASSP supported zones; design and implement activities directed specifically to their needs and interests.

Acronyms

ASSP	Accès aux Soins de Santé Primaires or Access to Primary Health Care Project
ATH	Access to Healthcare (former DFID Project)
BCC	Behavioural change communication
CODESA	Comité de Développement de l'aire de Santé or the Development and Health Committee
CsPRO	Census and Survey Processing System
CTMP	Comité Technique Multisectoriel Permanent or Permanent Multisectoral Technical Committee (for family planning)
CYP	Couple-years of protection
DFID	Department for International Development
DHS	Demographic and Health Survey
DMI	Development Media International
DPS	Division Provinciale de la Santé or Provincial Health Division
DRC	Democratic Republic of the Congo
ECC	Eglise du Christ au Congo
ECZs	Equipes Cadres de Zones de Santé or Cadre Health Zone Teams
EPI	Expanded Program on Immunization
FGD	Focus group discussions
FP	Family planning
HMI	Health Management Information Systems
HZ	Health zone
IP	Implementing partner
IT	Infirmier titulaire or head nurse
LARCS	Long-acting reversible methods
LAM	Lactational amenorrhea method
MCH	Maternal & child health
MCZ	Médecins Chef de Zone
MOH	Ministry of Health
MPSMRM	Ministère du Plan et Suivi de la Mise en œuvre de la Révolution de la Modernité
MSH	Management Sciences for Health
MSP	Ministère de la Santé Publique
NTDs	Neglected tropical diseases
ORIE	Operations Research and Impact Evaluation
PARSS	Health Sector Rehabilitation Support Project
PEP	Post-exposure prophylaxis
PMA	Minimum package of activities

PNC	Postnatal care
PNDS	Plan National de Développement Sanitaire
PNSR	Programme National de Santé de la Reproduction
PPS	Probability proportional to size
PRODEF	Programme d'Education Familial
PROSANI	Projet de Santé Intégré
RH	Reproductive health
SAFPAC	Supporting Access to Family Planning and Post-Abortion Care in Emergencies
SNIS	Système National d'Information Sanitaire or National Health Information System
SPHTM	Tulane School of Public Health and Tropical Medicine
TA	Technical assistance
TB	Tuberculosis
TOC	Theory of change
UNFPA	United Nations Population Fund
WASH	Water, Sanitation, and Hygiene

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I. Introduction

A. Background on the ASSP Project (Accès aux Soins de Santé Primaires)

The ASSP Project (Accès aux Soins de Santé Primaires, or Access to Primary Health Care Project) was awarded by the Department of International Development (DFID) of the Government of the United Kingdom to IMA World Health for a five-year project to strengthen the health system and improve health outcomes in 56 rural health zones of the Democratic Republic of the Congo (DRC). With a budget of $283 million, the ASSP project aims to reach at least nine million people from 2012 to 2018. The project has two main axes: health systems strengthening and direct support to many of its health zones through training, delivering of health supplies and commodities, and community based support through the implementation of community financing initiatives, establishment of community feedback mechanisms, and implementation of home based nutrition activities. The project involves the delivery of integrated health services, consistent with the DRC government policy on a minimum package of activities (PMA by its French acronym) and a complementary package of activities. The areas covered include HIV/AIDS, malaria and other communicable diseases, maternal newborn and child health, tuberculosis (TB), nutrition, water, sanitation and hygiene, neglected tropical diseases (NTDs), sexual and gender based violence, and family planning/reproductive health (FP/RH). Although all areas are important, DFID has requested that IMA World Health prioritize FP and RH.

IMA World Health works with partners at multiple levels. Its primary partner in this effort to strengthen health systems and improve health outcomes is the Ministry of Health (MOH): at the central, provincial, and health zone (HZ) levels. When the project began, ASSP was expected to operate in 56 HZs over five provinces. However, in March of 2015 a presidential ordinance was enacted calling for a new administrative configuration of the country's provinces, such that the existing 11 provinces were divided into 26. The former Kasai Occidental was split into 2 provinces, Kasai and Kasai Central, both of which contain ASSP health zones; Equateur was split into 5 provinces, with ASSP health zones concentrated in Nord Ubangi; Province Orientale was split into 4 provinces with ASSP health zones concentrated in Tshopo; Maniema remained one province as did Sud Kivu (see Table 1 and Figure 1). Additionally, in March 2015 two health zones in Sud Kivu were dropped from the project and the remaining two were dropped as of September 2015. Therefore, the project supported 56 health zones until March 2015, 54 health zones from April to September of 2015, and 52 health zones starting in October 2015.

Table 1. Provinces containing ASSP-supported health zones

Original province	New province(s)	Number of ASSP-supported health zones	Number of ASSP-supported facilities
Equateur	Nord Ubangi	11	180
Kasai Occidental	Kasai	17	381
	Kasai Central	11	161
Maniema	Maniema	10	154
Orientale	Tshopo	3	57
Sud Kivu	Sud Kivu	4	69
Total		**56**	**1,002**

IMA World Health works with a number of subcontractors responsible for different aspects of the project. Of key interest to this report are Pathfinder International (responsible for RH/FP) and Tulane School of Public Health and Tropical Medicine (SPHTM), responsible for Operations Research and Impact Evaluation [ORIE]).[1] This case study on family planning represents one of Tulane's deliverables under the portfolio of ORIE research.

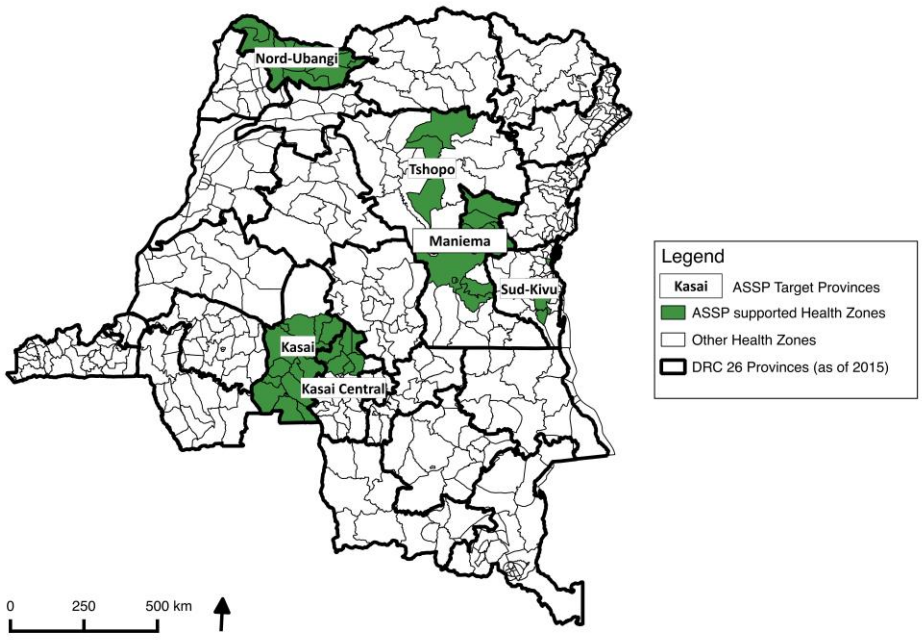


Figure 1: Map of the DRC health zones supported by ASSP

[1] Other subcontractors include IntraHealth (for human resource development) and Health Information Systems Program (for information systems), as well as ASSP partner organizations that implement in the following provinces: CARITAS (in Tshopo and Maniema), SANRU (in Kasai and Kasai Central), World Vision (in Nord Ubangi) and IRC (in Sud Kivu).

B. Theory of Change for ASSP Project

The ASSP Project has an overarching theory of change (TOC) that illustrates the pathways by which the project expects to achieve its desired effects; that is, the set of interventions that are hypothesized to result in the desired outputs and outcomes. The family planning component adheres to this same TOC. As shown in Figure 2, the project provides two types of assistance: (1) support for service delivery, in the form of training, supervision, commodities, and ORIE; and (2) capacity building and technical assistance (TA) at the central level of the MOH. The first of these two are expected to strengthen public health sector components at the provincial, HZ, facility, and community levels (through multiple interventions listed in the figure), with four results: enhanced service delivery and quality, increased community empowerment, and improved access to services. (A separate water, sanitation, and hygiene intervention in targeted areas is also expected to improve environmental conditions.)

Simultaneously, the capacity building work with the MOH aims to enhance government capacity for key functions: accountability and responsiveness; policy setting, implementation and control; and information management, among others. These two streams of activities are expected to jointly contribute to sustainable high quality essential health services, including family planning, which will in turn result in improved reproductive, maternal, neonatal, and child health outcomes.

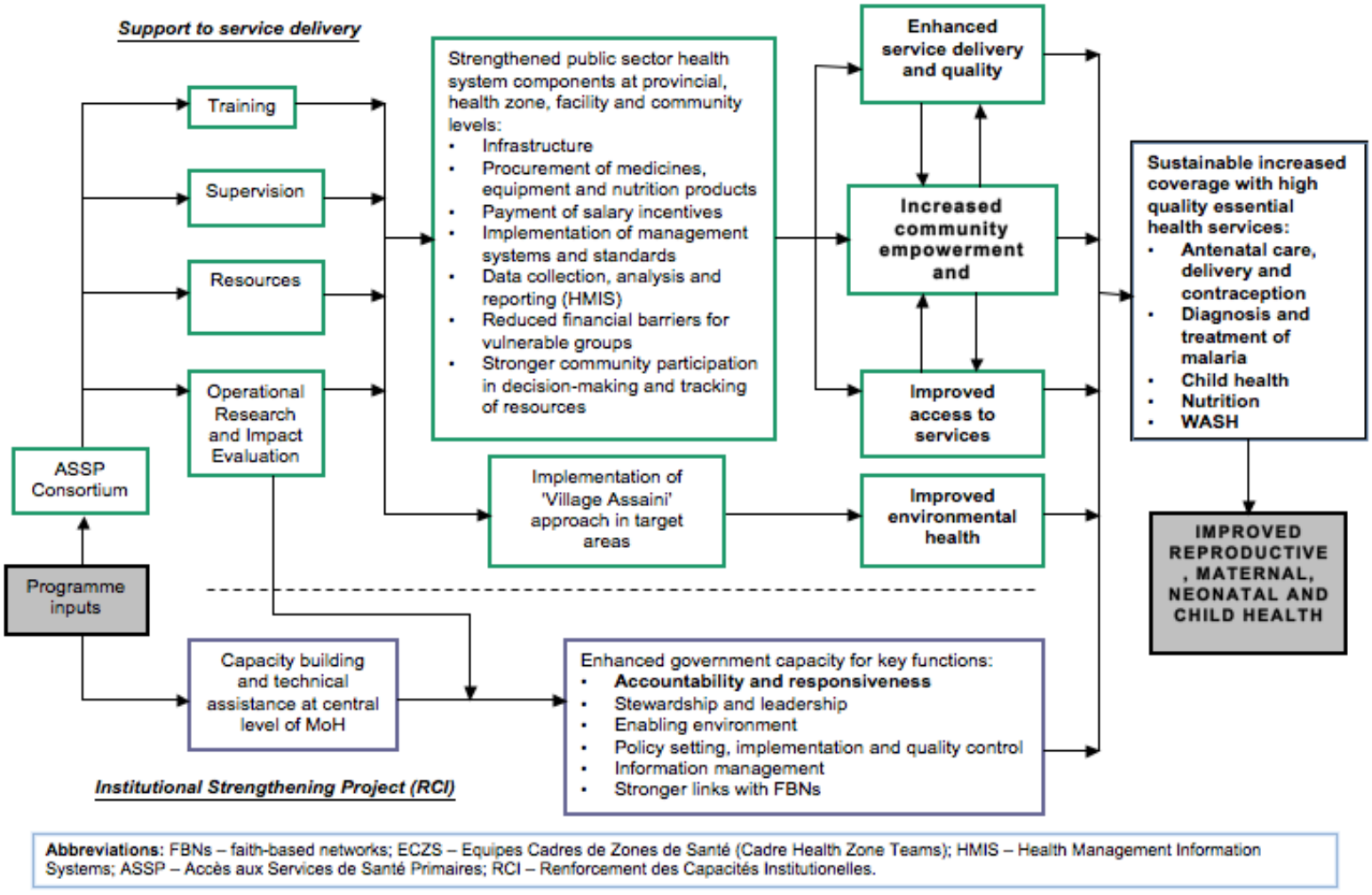


Figure 2. Theory of Change for the ASSP Project

C. Importance of family planning to improving health outcomes

As previously mentioned, family planning is one of the elements in the PMA and one of the priority interventions for the ASSP project. Multiple factors justify the promotion of increased use of contraception. Family planning and maternal health are inextricably linked; increasing contraceptive use in developing countries has reduced maternal mortality by about 26% in just over a decade, by avoiding high-risk pregnancies and unsafe abortions (Cleland et al., 2012). An analysis by Ahmed et al. (2012) of maternal mortality data from 172 countries estimated that satisfying unmet need for contraception could prevent another 104,000 maternal deaths per year. Contraceptive use is also associated with decreased child mortality; nearly 10% of children's deaths could be averted through increased contraceptive use in countries with high birth rates (Cleland et al., 2006). In one controlled trial, children in areas with access to family planning services had a higher body mass index, on average, than those in control areas (Canning, 2012).

From a human rights standpoint, access to family planning provides "freedom from the tyranny of excessive fertility" in allowing women to decide when and how many children to have (Cleland et al., 2006). Evidence from countries worldwide indicates that reducing fertility has positive effects on family economies. With fewer children, more resources are invested in the education, health, and well-being of each individual child (Carr et al., 2012). As women's earnings, assets, and empowerment improve, more women are able to enter the workforce and youth dependency is reduced (Canning, 2012). As women gain greater incomes, they are able to invest more in the health and education of their families (Petruney, 2014). Gender equity and women's status in society also improves (Singh & Darroch, 2012).

In recent years, numerous developing countries have begun to consider how family planning contributes to the achievement of the demographic dividend. The demographic dividend is the surge of economic growth that can result from a change in the country's population age structure due to declining fertility rates and increased number of adults in the working-age population. Rapid economic growth is possible if investments are made in social programs such as healthcare and education (Petruney et al., 2014; Population Reference Bureau, 2013). Increasing the ratio of working adults to dependents creates a window of economic opportunity within countries, driving rapid improvements in the standard of living and quality of life in the countries where it occurs (Carr et al., 2012). Investments in family planning are thus cost-effective in their ability to reduce poverty, aside from health and human rights benefits (Bongaarts & Sinding, 2011).

D. Family planning within the ASSP Project

This project, led by IMA World Health and financed by DFID, has been operational since April 2013 and is expected to be complete by March 2018. ASSP is currently in Year 3 of the project, as project years run from April to March. In addition, ASSP reports quarterly on its progress. Quarter 1 covers April to June of 2013 and Quarter 11, the most recent completed quarter, covers October to December of 2015.

ASSP is working to integrate family planning into all aspects of maternal health care, making family planning services more easily accessible to women in the DRC. The actual work related to family planning, for which Pathfinder International is the lead subcontractor, began in 2013.

The log frame for the ASSP project includes three items relevant to family planning, which are as follows:

- Number of couple-years of protection (CYP)
- Number of new acceptors of modern methods of family planning
- Number of facilities reporting drug stock outs of any of the five tracer drugs, including Depo-Provera

Section VII of this case study presents the specific activities conducted by Pathfinder International, the FP subcontractor on the ASSP project, in support of these objectives.

II. Objectives of this Case Study

Given the importance of family planning within the ASSP project, DFID and IMA World Health agreed that one of the eight ORIE studies should focus on family planning. In this case study we combine multiple sources of data (quantitative and qualitative) to understand how well the FP component of the project has performed to date: what have been the major accomplishments; what have been the major challenges; and what midcourse corrections might increase modern contraceptive prevalence rate (mCPR) by the end of the project in 2018.

ASSP has an impact evaluation component, consisting of a baseline survey (conducted in 2014) and endline survey (expected in 2017) to measure both population-based outcomes and facility-based indicators. These surveys will measure a number of behaviours and outcomes in both treatment areas (supported by ASSP) and comparison areas (not supported by ASSP). The data will be analyzed to determine the effectiveness of the ASSP interventions across a wide range of health topics to change behaviours and improve outcomes. By contrast, the current case study attempts to analyze the implementation of the FP interventions (similar to a process evaluation) and to report on the outputs achieved to date. It does not measure impact.

This case study draws on evidence from multiple sources: both existing information from surveys and program records, and primary data collection at the field level: focus groups (among women and men in selected HZs supported by ASSP in three provinces) and in-depth interviews among MOH officials at the provincial and HZ levels.

The objectives of this case study are to:

1. Present the context for family planning in an integrated health services project in the DRC in terms of:
    a. Previous large-scale integrated health services projects
    b. Political context for family planning in the DRC

2. Examine contraceptive use dynamics in the ASSP-supported HZs at the start of the project (population-based data from the baseline survey):
    a. Modern contraceptive prevalence
    b. Method mix
    c. Correlates of modern contraceptive use
    d. Unmet need for family planning

3. Assess the readiness of health facilities in the ASSP-supported areas to provide FP services;

4. Describe the family planning inputs and activities implemented in relation to the government's Plan National de Développement Sanitaire (PNDS) 2011-2015 (National Health Development Plan) priority pillars:
    a. Service delivery
    b. Human resources for health
    c. Medications and specific inputs/infrastructure and equipment
    d. Health information
    e. Health financing
    f. Governance

5. Analyse FP performance in ASSP-supported health zones based on output indicators:
    a. Indicators of uptake (CYP and new acceptors): by year and by province
    b. Method mix, including the overwhelming popularity of the implant

6. Assess the attitudes of key stakeholders toward family planning in the ASSP project
    a. MOH personnel at the central and provincial level
    b. Medecins chefs de zones
    c. Implementing Partners (IP)
    d. Community members (married women and men, and unmarried young people)

7. Based on the findings, make recommendations for midcourse corrections in the family planning component of the ASSP project.

III. Methodology

A. Sources of data

The case study used a combination of data sources (both qualitative and quantitative) to examine different research questions. This mixed method approach allowed us to triangulate data from the different sources shown in Table 2.

Table 2. Sources of data by objective in this case study of FP in the ASSP Project

Objective	Topic	Sources of data
1-a	Review of previous large-scale integrated health projects and other projects designed to increase mCPR in rural areas of the DRC	Literature review
1-b	Political context for family planning in the DRC (with implications for ASSP)	Literature review; key informant interviews with MOH personnel
2.	Contraceptive use dynamics in the ASSP-supported HZs at the start of the project	ASSP baseline household survey, conducted in 2014
3.	Readiness of health facilities to provide FP services	ASSP baseline facility-based survey, conducted in 2014
4.	Inputs for the FP intervention in the ASSP Project	Interviews with IMA World Health and Pathfinder staff and review of project documents
5.	Family planning performance as measured by CYP and new acceptors	Service statistics provided by IMA World Health to Pathfinder for use in quarterly reports; analysed using revised CYP targets
6.	Attitudes of stakeholders toward family planning in the ASSP project	Key informant interviews and focus group discussions

B. Data collection and analysis

1. Literature review

The purpose of the literature review was to provide context for this report, especially to better understand the evolution of large-scale integrated health programs and the

performance of family planning within them. To this end, the literature review focused on peer reviewed literature, reports of program evaluations, and other "grey" literature describing such programs. The main search engines used were Pubmed, CINAHL and MEDLINE. We supplemented these with Google Scholar. We attempted to find all published articles and reports from the grey literature, starting from the year in which President Mobutu first announced the concept of "naissances desirables" (1972). However, the actual references that we located dated from 1982 to 2015.

2. ASSP baseline household survey

The ASSP baseline survey, which provides data for an impact evaluation using a quasi-experimental design (baseline/endline in intervention and comparison), was conducted in April and May of 2014. The baseline survey covered five of the six ASSP supported provinces (Tshopo, Maniema, Nord Ubangi, Kasai, and Kasai-Central).

At the beginning of the project, ASSP defined three project pools, largely based on geography. In each project pool an Implementing Partner was selected for carrying out ASSP activities. The pools were created as follows:

- Kasai and Kasai Central: 28 health zones implemented by SANRU
- Nord Ubangi: 11 health zones implemented by World Vision
- Tshopo and Maniema: 13 health zones implemented by CARITAS

The ASSP impact evaluation used the same project pools to define sampling areas[2]. This was done for a two reasons: (1) given that socio-demographic and behavioural factors may differ simply due to geographic differences, the creation of three separate sampling areas helped differentiate those changes truly related to the studied interventions from the changes that would occur over time even in the absence of these interventions; and (2) it allowed for geographically representative estimates of population coverage and outcomes to be made for the sampling areas.

The research team obtained comparison groups by randomly selecting villages within health areas outside of ASSP-supported health zones, matched as closely as possible on key socio-demographic variables, which would not receive the ASSP intervention package.

In ASSP sampling areas, a two stage sampling strategy was used. At the first stage, a total of 35 villages per sampling area (35*3 = 105 intervention villages in total) were selected using probability proportional to size (PPS). At the second stage, after the villages were entirely enumerated, a constant number of households per village (20) were systematically selected to obtain the desired sample size of 700 households in each sampling area, or 2,100

[2] In this context, a "sampling area" is synonymous with a "survey domain."

total. Although the baseline study collected data from both the intervention and comparison areas, the analysis in this FP case study is limited to the intervention areas only.

The data was collected by a pencil-and-paper survey, transcribed into computer-readable format using Census and Survey Processing System (CsPRO) based on a double entry system to detect and correct errors, and cleaned. The data analysis team used Stata 13 to generate the tables for the ASSP baseline survey.

3. ASSP baseline facility-based survey

The facility-based survey used a convenience sample of one health facility for each sampled village in the household survey (described above). As the sample for the household survey consisted of one village per health area, the health centre officially designated to serve households in that health area was included in the facility survey, which resulted in a total of 105 facilities in the intervention areas. For each selected health facility, the head of the facility and all health care providers on duty the day of the survey were interviewed using a structured questionnaire.

The data collection, cleaning, and analysis were performed in the same way as for the baseline survey (described above).

4. Compilation of data on inputs to date to the FP component of ASSP

The Technical Advisor/Director for Reproductive Health and Family Planning and the Monitoring and Evaluation Advisor for the ASSP project provided information about ASSP's family planning activities. Information was compiled from ASSP program documents such as the official list of supported health facilities, the list of FP commodities distributed to date, training records, and ASSP quarterly reports.

5. Service statistics

To track progress under the ASSP Project, IMA World Health has set up an internal system to collect and monitor routine service statistics relevant to the objectives of the project. Although IMA is working to strengthen the National Health Information System (Système National d'Information Sanitaire, or SNIS) and hopes to be able to obtain its routine monitoring data exclusively from the SNIS in the future, as of this report it is not yet fully functional. In the meantime, ASSP is using a combination of DHIS 2 data and data from paper copies of the SNIS reports entered into an excel sheet by the IPs in order to report on service statistics, including family planning statistics. IMA World Health provided the data set to Tulane for the purpose of this analysis. Specifically, it consisted of the raw data available as of December 2015, on the number of contraceptives distributed in the 56 health zones served by ASSP over 11 quarters from April 2013 to December 2015. (The number

of zones decreased to 52 during the course of 2015.) IMA also provided Tulane with the CYP conversion factors it had used in calculating CYP.

As background to this report, Tulane has conducted two analyses of the CYP targets:

- "Analysis of Trends in Couple-Years of Protection (CYP) in 56 ASSP-funded Health Zones in the Democratic Republic of the Congo (DRC)," (August 26, 2015)
- "Revising the CYP Targets for the ASSP project," (February 10, 2016)

The first document identified two errors in the conversion factors for CYP that the SNIS had mandated for use in the country and that IMA World Health/Pathfinder had adopted for its calculations of CYP. In October 2015, the SNIS indicated its intention to correct these factors in future calculations. Based on this, at the request of DFID and IMA World Health/Pathfinder, Tulane prepared revised CYP targets for the ASSP project. DFID and IMA World Health/Pathfinder accepted these new targets in March 2016, and the current case study reports on project achievement against these revised CYP targets.

6. Qualitative data collection (key informant interviews and focus group discussions)

Two types of qualitative data were collected specifically for the purpose of this case study: key informant interviews and focus group discussions (FGD). All data were collected between August and September 2014, in six rural health zones: two each in the three provinces mentioned above. IMA World Health/Pathfinder assisted the research team in purposefully selecting a "relatively strong" and a "relatively weak" health zone in each province, in terms of family planning performance (and reasonably accessible), with the aim of revealing both strengths and areas for improvement at the field level. FP performance was assessed in terms of the number of CYP generated by the health zone. "Atypical" health zones were excluded from selection. The health zones selected as "strong" and "weak" (respectively) were Kampene and Alunguli (in Maniema), Mutoto and Mweka (in Kasai), and Bosobolo and Bili (in Nord Ubangi).

Key informant interviews. The key informants were purposively selected, based on the position they held. The team interviewed provincial MOH officials and staff of IP organizations in the three provinces selected for this research: SANRU in Kasai, World Vision in Nord Ubangi, and CARITAS in Maniema. In addition, five staff from IMA/Pathfinder in Kinshasa were interviewed. All key informant interviews were audio recorded and hand written notes were taken to provide additional insights into the interviews.

Table 3. Number and positions of key informants interviewed for this study

	Nord Ubangi	Maniema	Kasai	Kinshasa	Total
MOH personnel	3	3	3	3	12
Médecins Chef de Zone (MCZ) (one per HZ selected for the qualitative research)	2	2	2	--	6
ASSP IPs	2	2	2	2	8
Total	7	7	5	5	26

Focus group interviews. A total of 36 focus groups were conducted among women and men in the communities supported by ASSP. They took place in the six communities listed above (one "strong" and one "weak" in each of the three provinces). Within each community, the team conducted six focus groups, one each among participants fitting the criteria listed in Table 4. Each focus group had 10 to 12 participants.

Table 4. Characteristics of the participants and number of focus groups conducted, by province

Characteristic of the participants	Nord Ubangi	Maniema	Kasai	Total
Married women aged 20-30 who use contraception	2	2	2	6
Married women aged 20-30 who do not use modern contraception	2	2	2	6
Unmarried women 18-24 with no children	2	2	2	6
Married men aged 25-34 who use/whose wives use contraception	2	2	2	6
Married men aged 25-34 whose wives do not use contraception	2	2	2	6
Unmarried men aged 18-24 with no children	2	2	2	6
Total	12	12	12	36

The age ranges were selected to include the married women during their peak reproductive period and husbands whose wives might likely (though not necessarily) be in this same peak reproductive period. The age range was limited in each case to improve group dynamics; the presence of older men or older women might have hindered the spontaneous flow of ideas among younger participants.

By contrast, the 18-24 year olds were selected to represent young people before they had any of the responsibilities of marriage or children, but were more likely to face barriers to accessing contraception.

The research team worked with local community leaders to identify potential participants in the focus groups. It was preferable to have participants who did not know each other, but this was almost impossible to attain in a rural community. The team made every effort to avoid including community leaders or opinion leaders as participants in the focus groups. All formal group discussions were audio recorded and hand written notes were taken to complement this information.

Analysis of the key informant interviews and focus group discussions. Audio recordings were translated and transcribed from the local language into French and transcriptions were prepared in a Microsoft Word document. Researchers reviewed the transcripts and developed a coding system derived from the initial research themes and questions, as well as key concepts that emerged during data collection. Coding of the interview transcripts was done using EPI (Expanded Program on Immunization) Data. Content analysis was used to identify trends of concepts in and across individual codes. Data triangulation was used to ensure that the findings were validated across different respondents, and between key informant interviews, in-depth interviews, and group discussions.

C. Human subjects review

Ethical approval of the study and data collection procedures was obtained from the Institutional Review Boards of Tulane University (reference # 717117) and the Kinshasa School of Public Health (reference # ESP/CE/0901/2015) before data collection commenced. Oral informed consent was obtained from all participants in the qualitative study prior to the interviews.

IV. Context for this assessment

A. Previous large-scale integrated health programs in the DRC

ASSP is the most recent in a series of large-scale integrated health projects in the DRC (and in Zaire, before the name of the country changed to the DRC in 1997). Table 5 summarizes these projects, which went under the acronyms SANRU I, II, and III, AXxes, ATH (Access to Health), Health Sector Rehabilitation Support Project (PARSS), Projet de Santé Intégré (PROSANI), and most recently, ASSP. These projects operated in selected HZs; SANRU II had the largest reach, operating in 150 HZs in the country. HZs may receive additional support for specific interventions (e.g., HIV, malaria), apart from the more comprehensive integrated health projects. Other HZs have been beneficiaries of efforts by Protestant or Catholic missionary groups. At present more than half of the HZs in the country are not covered by an integrated health project. Moreover, these large-scale projects do not necessarily cover all health areas (*aires de santé)* – subdivisions within a HZ – in the HZ they support.

Table 5 lists the diseases/health topics covered by each of these large-scale integrated projects. They are very similar across projects: malaria, maternal and child health, TB, water and sanitation, nutrition, and FP, among others. HIV interventions were not added until the late 1980s. Gender-based violence was first included in the AXxes Project, beginning in 2006.

Figure 1, presented above, shows a map of the HZs that receive support (as of January 2015) from ASSP.

Table 5. Large Rural Integrated Health Projects in Zaire/DRC: 1981 to present

Project Name	SANRU	SANRU II	SANRU III	AXxes	PARSS	ATH	PROSANI	ASSP
Full Name	Soins de Santé Primaires en Milieu Rural	Soins de Santé Primaires en Milieu Rural	Soins de Santé Primaires en Milieu Rural	AXxes	Projet d'Appui à la Réhabilitation du Secteur de la Santé	Access to Healthcare	Projet de Santé Intégré	Projet d'Accès aux Soins de Santé Primaire
Lead Agency	Eglise de Christ au Zaïre	Eglise de Christ au Zaïre	IMA World Health *Key Partner: Eglise du Christ au Congo	IMA World Health	Congolese Ministry of Health	Medical Relief International (Merlin) and International Rescue Committee (IRC)	Management Sciences for Health	IMA World Health
Operational Years	1981-1986	1986-1991	2001-2006	2006-2011	2006-2014	2008-2013	2011-2016	2012-2018
Donors	USAID	USAID	USAID	USAID	World Bank	DfiD	USAID	DIFD, Swedish International Development Cooperation Agency
Budget (in U.S. dollars except where noted)	No data	No data	$26.6 million	$60 million	$335 million	£ 79,999,994	$139,767,129 (Budget for 5 year- without 1 year extension)	$283 million

Key Partners	ECC/DOM[3], Tulane University, CNPPND[4]	ECC/DOM, Tulane University, CNPPND	ECC/DOM Tulane University, PRONANUT[5], Advance Africa, American Baptist Church, Catholic Relief Services, Johns Hopkins University, Mennonites	Catholic Relief Services, ECC/DOM, World Vision International Helen Keller International, Johns Hopkins University, Health Information System Program, Management for Science Health	CCISD[6], Cooperation Technique Belge, Credes[7], COOPI[8], GTZ[9], IRC[10], Sofreco, MOH, Cadre Health Zone Teams (Equipes Cadres de Zones de Santé, or ECZ)	UNICEF	IRC, Overseas Strategic Consulting, Ltd.	CARITAS[11], SANRU, World Vision, Pathfinder, IntraHealth, Tulane University, IRC, Health Information System Program

[3] Eglise du Christ au Congo, Direction des Œuvres Médicales
[4] National Council for the Promotion of Desirable Births
[5] Programme National de Nutrition
[6] The Centre for International Cooperation in Health and Development
[7] Centre for Research and Documentation in Health Economics
[8] Cooperazione Internazionale
[9] German Technical Cooperation Agency
[10] International Refugee Committee
[11] Caritas International

Table 6. Health Areas Covered by Large-scale Integrated Rural Health Projects in Zaire/DRC

Health Area	SANRU	SANRU II	SANRU III	AXxes	PARSS	ATH	PROSANI	ASSP
Family Planning/ Reproductive Health	✓	✓	✓	✓	✓	✔	✓	✓
HIV/ AIDS		✓	✓	✓	✓	✔	✓	✓
Malaria and other Communicable Diseases	✓	✓	✓	✓	✓	✔	✓	✓
Maternal, Newborn and Child Health	✓	✓	✓	✓	✓	✔	✓	✓
Tuberculosis	✓	✓	✓	✓			✓	✓
Nutrition	✓	✓	✓		✓	✔	✓	✓
Water, Sanitation & Hygiene	✓	✓	✓	✓			✓	✓
Neglected Tropical Diseases	✓	✓	✓				✓	✓
Sexual and Gender Based Violence				✓	✓			✓

Sources: (IMA World Health, 2006; IMA World Health, 2011; IMA World Health, 2013; Management Sciences for Health, 2015; Miatudila et al., 2006; DfiD, 2013; USAID, 2013; USAID, 2014; O'Grady et al., 2013; PARSS, 2014

SANRU I, II, & III (Projet Santé Rurale; Rural Health Project)

The tradition of large-scale integrated rural health programs in Zaire began with the USAID-funded project SANRU I, which ran from 1981-86 and operated in 50 rural health zones. SANRU II (1986-91) expanded to reach 150 health zones. In 1991, USAID and most development partners were forced to withdraw from the country as a result of political violence and social upheaval that continued for at least a decade. In 2001 USAID continued its support, signing a five-year agreement with the MOH for SANRU III, which operated under the direction of IMA World Health in partnership with Eglise du Christ au Congo (ECC) in 56 HZs.

The main objective of the three waves of SANRU was to strengthen the capacity to provide primary care delivery within their health facilities. Results from the evaluation of SANRU III showed a significant increase in the capacity of the 56 health zones to provide a wide range of primary health care, including family planning. Among many other accomplishments, SANRU III increased malaria control activities, behaviour change communication activities, nutritional interventions, and access to safe and clean water (Miatudila et al., 2006). However, one of the major issues with SANRU III was its lack of an accountable monitoring and reporting program. The audit completed by USAID to better understand the monitoring and reporting system found numerous problems; incomplete records and a lack of supervision at the project sites revealed possible inaccuracies in some portion of the service statistics and program records (USAID, 2004).

SANRU I and II did not conduct population-based surveys for purposes of evaluation, whereas SANRU III did. At baseline (2001) the mCPR was 0.5%; by 2005, it had increased to 11.4% (Miatudila et al., 2006). SANRU III also tracked CYP. In total, SANRU III had provided 60,720 CYP (Note: the CYP output included condoms, IUDs, Cyclebeads, injectables, pills, implants, surgical methods, and lactational amenorrhea.)

AXxes

The AXxes Project, also funded by USAID, followed onto SANRU III in 2006 and ran until 2011. Also implemented by IMA World Health, the project was designed to help revitalize 57 health zones in the former East and West Kasai, Katanga, and South Kivu provinces. This included all former SANRU III health zones in East Kasai and Katanga, and most former SANRU III health zones in West Kasai. The health zones in South Kivu were all new. This project included multiple components including integrated service delivery, women's health, fistula prevention and repair, FP, malaria prevention and treatment, health infrastructure, water and sanitation, and health management information systems. With regard to family planning, AXxes aimed to protect the health of women and children by encouraging and educating women to space their births and to use modern contraception (USAID, 2013). Increasing gender awareness and preventing sexual/gender based violence was also one of the core components of AXxes. The AXxes model mandated that every woman who visited a health clinic should be counseled and educated on the

contraceptive options that the facility had in stock. After four years, the number of new acceptors had increased by 20% (USAID, 2013). As part of its behavioural change communication (BCC) strategy, AXxes used radio messages and over 10,000 print materials to reach the population. However, due to the absence of a monitoring system, it was impossible to measure the reach and effects of the BCC interventions (USAID, 2013; USAID, 2014).

The final evaluation of the project showed that it had generated 101,398 CYP, a measure of FP output. (Note: the CYP output included condoms, Cyclebeads, Depo-Provera, pills, surgical methods, as well as lactational amenorrhea and methods of self-observation.)

PARSS

PARSS was a World Bank funded project that operated within the 84 HZs within the former provinces of Bandundu, Equateur, Katanga, Kinshasa, and Maniema. This project was operational from 2006-2014. The main objective of PARSS was to increase access to and ensure use of essential medicines within the targeted HZs. The health areas in which PARSS worked were malaria, HIV/AIDS, nutrition, sexual and gender based violence, maternal, newborn, and child health, and FP. An interesting component of the project was the use of results-based financing, whereby individual health facilities were given financial incentives for reaching certain performance criteria such as additional units of key services provided (e.g. one more assisted delivery), based on the quality and quantity of services that they provided. In PARSS-supported areas, the number of new acceptors of contraceptives quadrupled from 2% to 8% (PARSS, 2014). However, due to frequent stockouts of contraceptive methods caused by late deliveries by the United Nations Population Fund (UNFPA), contraceptive needs remained largely unmet by the close of the project in 2014. Another obstacle that PARSS faced was the fact that 80% of people in Equateur live along the Congo River (PARSS, 2014). Providing access to such a rural and inaccessible population proved to be extremely challenging. As of 2015, the final evaluations had not yet been published.

Access to Healthcare (ATH)

Access to Healthcare (ATH), funded by DFID, provided support of primary health care across 20 health zones in four provinces: Kasaï Occidental, Maniema, Province Orientale, and South Kivu from 2008-2013. Two international NGOs managed the project: Medical Relief International (Merlin), which operated in 10 of the 18 health zones in Maniema province; and International Rescue Committee (IRC), which worked in three zones in Kasaï Occidental, three in Province Orientale, and four in South Kivu. The original goal statement for the program was to address high levels of mortality and illness in DRC. In 2011, the project goal was modified as follows: "To contribute to improved health status of the population of DRC, particularly child, maternal and reproductive health," based on a change in country operational plan priorities (DFID, 2013). The objectives of the project were to increase access to antenatal and delivery services, use of

modern contraceptives, and access to child services; to improve prevention, diagnosis and treatment of malaria; and to strengthen managerial capacities of health zone teams.

According to project documents, the project constructed large numbers of health facilities and demonstrated that motivation improved among health facility staff. There was progress on key health indicators and community involvement in services. From 2008-2013, the program enabled a total of 373,093 deliveries to take place with the help of a skilled birth attendant. For emergency obstetric care, December 2012 indicators showed that 100% of health centers and 83% of reference health centers and hospitals (97% of facilities overall) provided the appropriate level of EOC. However, by March 2013 nine facilities had "ceased to provide the appropriate level of EOC", which reflects the lack of sustainability of the intervention. Results were similar for the provision of contraceptives. FP results differed markedly between health zones serviced by IRC and by MERLIN, and in the final quarter of the project, the proportion of health centers providing modern contraception dropped from 76% to 70.5%. Despite these issues of supply and sustainability, in the final year of the program 57,891 CYP were achieved.

Overall, the program did not meet overall expectations, earning a DFID grade of B; however, it was relatively successful in terms of delivery of maternity and reproductive health services, vaccination and distribution of bed nets. Programmatic challenges related to staff and supply chain issues. There were also theoretical issues arising from the distribution of free healthcare and the cultural undesirability of "charity". However, all beneficiary groups expressed a strong desire for program continuation and made commitments to support ASSP. Activities under the ATH project were extended until ASSP began. Another lesson learned was the difficulty of having two organizations with two different approaches to delivering healthcare to vulnerable people directing the project interventions, which led to the rationale for the "program managed approach" in ASSP (DFID, 2013).

PROSANI

This project, funded by USAID and implemented by Management Sciences for Health (MSH), targets 80 health zones in four provinces (formally Katanga, Sud Kivu, East Kasai, and West Kasai) (O'Grady, 2013). The original project ran from 2010-2015 and USAID added an additional 1-year extension. In many ways, PROSANI is the program most similar to ASSP, as both are considered "appui global" (global support) programs designed to support the government's PNDS priority pillars for health. The two programs are operating concurrently, although in different areas of the country. Moreover, both were designed to have an impact evaluation involving a baseline and endline survey, although methodologies differ.

PROSANI's main objective is to improve the enabling environment for, and increase the

availability and use of, high-impact health services, products, and practices for family planning; maternal, newborn, and child health; nutrition; malaria; neglected tropical diseases; tuberculosis; HIV/AIDS; and water, sanitation, and hygiene (WASH) in target health zones (O'Grady, 2013). In doing so, PROSANI includes two components. The first involves strengthening the HZ's capacity to deliver quality services, addressing both the supply and demand needs. The second involves looking at the broader health systems strengthening goals at the health zone level, focusing on leadership and governance.

Two baseline surveys were conducted in PROSANI project areas. The first was conducted in 2011 by MSH and included a community and household based survey. The second, conducted in 2013 by International Business and Technical Consultants, Inc., two years after the start of the program, included a facility-based survey. An endline survey was also conducted in 2015, however as of December 2015 the report had not yet been published. The PROSANI project did, nevertheless, host a results dissemination event in December 2015 to present preliminary results. According to that presentation, between October 2010 and September 2015 the PROSANI project had trained over 3,000 health workers and over 3,000 community-based distributors in FP and supported 2,230 health facilities and community based sites to provided FP services (PROSANI, 2015). In addition, the project conducted over 560,000 FP counseling sessions, achieved over 500,000 new acceptors, and provided over 600,000 CYP.

In short, ASSP is the latest in this series of large-scale integrated health projects in the DRC. It was similar to its predecessors in that family planning was integrated into a larger number of primary health care topics. In those projects financed by USAID, family planning was of interest to the donor but did not necessarily receive special priority vis-à-vis other health topics. All projects (except PARSS) tracked FP results using CYP, which is calculated based on the volume of contraception dispensed to clients through the project.

ASSP differs from predecessor projects in two important ways. First, ASSP has a stronger emphasis on FP then previous projects. Specifically, DFID (the donor) has instructed IMA World Health that if it has not reached its FP target by Year 3 of the project it should reprogram its funding to give greater emphasis to the FP component. Second, the ASSP project is the only project in this series to be evaluated using a before-after survey in intervention and comparison areas, at both the household and facility level.[12]

Other FP interventions in the DRC

In addition to these large-scale integrated health projects, there have been several isolated examples of projects intended to increase mCPR in one or more HZs of Zaïre or the DRC. One of the earliest projects was PRODEF (le Programme d'Education Familial), which operated in one rural HZ in the former Bas Zaire (Nsona Mpangu) and the city of Matadi from 1981-1989. It later

[12] The PROSANI evaluation did not include comparison/control areas.

expanded to include a second rural HZ in Bas Zaire: Sona Bata. Population-based surveys in all HZs showed an increase in mCPR, to 23% in Matadi in 1989, 8% in Nsona Mpangu, and 6% in Sona Bata by 1988 (Bertrand et al, 1986; Bertrand et al., 1993).

Similarly, the HZ of Vanga (former province of Bandundu) was known to be very active in FP in the 1980s, as a result of the work of a missionary group headed by Dr. Dan Fountain. A special population-based study of the HZ showed mCPR to be 11% as of 1983 (Westinghouse Health Systems, 1983).

From 1991 to the early 2000s, little organized FP work occurred in rural HZs in a systematic fashion, although some FP work was being conducted in Kinshasa and in West Kasai.

In the past decade there has also been considerable FP programming in Eastern Congo in conjunction with refugee work. CARE's Supporting Access to Family Planning and Post-Abortion Care in Emergencies (SAFPAC) works to supply family planning to one of the most vulnerable populations in the DRC. Of the 123,218 women of reproductive age in the catchment area, 14,869 women became new users of modern contraception after visiting a SAFPAC clinic (Curry et al., 2015).

Despite these previous efforts to increase contraceptive use, the 2007 DHS showed the prevalence of mCPR to be 5.8% for married women ages 15-49 (9.5% in urban areas and 3.3% in rural areas). By 2013-14 the mCPR had risen minimally to 7.8% for married women ages 15-49 (14.6% in urban areas and 4.6% in rural areas).

B. Position of the DRC government on FP

The 10-15 years of political turmoil and social unrest, starting in 1991, left the country in chaos, with few resources or political resolve to address public health problems. The country began the slow road back to normalcy in the mid-2000s.

In terms of family planning, the DRC government established the Programme National de Santé de la Reproduction (PNSR) in 2001, with the complementary objectives of decreasing maternal mortality and promoting FP. However, resources were extremely scarce when PNSR began its work, and FP was not a government priority.

As USAID began to rebuild its health portfolio in the DRC, it worked with the PNSR to support the First Conference to Reposition Family Planning; however, it did little to revitalize FP activities. Five years later, in 2009, a Second Conference to Reposition Family Planning was held, this time under the auspices of the First Lady. This conference heightened visibility of FP, highlighting it as an important public health issue for all people. It also established the multisectoral committee of family planning stakeholders (Comité Technique Multisectoriel Permanent, CTMP). However, the government seemed indifferent or neutral to FP and there was little follow-through on the

recommendations of the conference (in fairness because so few resources were available for this purpose).

Starting in 2012, the DRC government has steadily increased its commitment to FP. The first sign of government interest was the inclusion of FP in the list of six elements to accelerate the achievement of the Millennium Development Goals 4 and 5. A year later, in 2013, the government allocated $994,000 from the national budget towards the procurement of contraceptives. In November of that year, the DRC made a public commitment to the FP2020 movement during the Third International Conference on Family Planning in Addis Ababa. In February 2015, the MOH officially launched the National Multisectoral Strategic Plan for Family Planning: 2014 – 2020. At the Third National Conference on Repositioning Family Planning in the DRC, held in December 2015, the government agreed to double its financial commitment to FP to $2.5 million (Mukaba et al., 2015). Most recently, the Prime Minister of the DRC accepted an invitation to speak at the Fourth International Conference on Family Planning in Indonesia. Although deterred from attending when the conference was rescheduled because of volcanic eruption, the DRC delegation was among the most visible at the conference. It took advantage of this to announce the creation of a budget line item for contraceptive procurement of an additional $3.5 million annually.

Developing a cohesive group of FP stakeholders has proven to have an impact on the FP policy environment. In 2015, the Office of the Prime Minister gave official status to the CTMP, making it a powerful coordinating body. Efforts are underway to establish provincial CTMP committees, with four established to date in Sud Kivu, Nord Kivu, Katanga, and Kinshasa. It is expected that with the expansion of the CTMP to the provincial level, the increasingly favorable policy environment in Kinshasa will translate to action in the other provinces in the country.

In short, the current government has shown more political will in support of family planning than any prior administration in the DRC. The participation of provincial officials in the development of the Strategic Plan, in the Third National Conference to Reposition Family Planning, and in the development of provincial CTMP provides a positive, enabling environment for the development of effective family-planning programs. At the same time, FP programming is faced with a multitude of challenges including deep-seated cultural norms that favor large families, weak infrastructure for the transport of commodities, weak health systems throughout the country, among others. Despite the tremendous challenges to expanding FP service delivery and modern contraceptive use in the DRC, the policy environment for FP in the DRC is among the strongest of any country in Francophone sub-Saharan Africa.

V. Contraceptive use dynamics at the start of the ASSP project

A. Purpose of this section

A baseline study conducted in 2014 provides a clear assessment of the status of FP in the areas supported by ASSP at the start of the project. Due to logistical delays, the baseline survey was conducted one year after the start of ASSP. ATH, the predecessor primary health care program, had previously provided family planning services to all 13 ASSP supported health zones in Maniema/Tshopo and to three ASSP supported HZs in the Kasais. When ASSP started in 2013, it was able to continue FP activities in these 16 HZs without interrupting service provision. For all other HZs included in the sample, ASSP FP activities did not start until March of 2014, around the same time as the survey.

This chapter examines key variables related to contraceptive use, including contraceptive prevalence, method mix, and unmet need. In addition, it identifies factors associated with modern contraceptive use. In short, it provides a snapshot of the FP situation among a representative sample of women 15-49 years old living in the ASSP-supported areas expected to benefit from the FP intervention.

Details of the methodology are presented in section III, above.

B. Socio-demographic profile of women in ASSP-supported areas

As shown in Table 7, 87.4% of the population in ASSP-supported zones lives in rural areas; the percentage ranged from 84.5% in Kasai/Kasai Central to 90.5% in Nord Ubangi. The population is young; the mean age of women in the survey was 28.3 years. The level of educational achievement is low; almost one-quarter (23.3%) of women had no formal education, 32.6% had some primary school education, and 40.0% completed primary school. Only 3.6% had completed secondary school or higher education. In terms of economic level, the survey classified women into wealth quintiles. The findings showed the highest levels of wealth in Maniema/Tshopo; Kasai/Kasai Central fell in the middle; Nord Ubangi showed the lowest levels of wealth. The vast majority of the population was Christian, including Protestants (22.6%), Catholics (22.2%), and other Christian (42.8%). Less than 4% were either Muslim or animist.

Four in five women in this population (80.5%) were married or in union, with a slightly higher percentage in Kasai/Kasai Central. The mean number of children per women was 2.8, with a higher mean number in Kasai/Kasai Central (3.0) than Nord Ubangi (2.5). However, many of these women have not completed their childbearing years. Table 7 shows the mean number of children by age groups of the women, reaching 5.0 children on average among women 45-49.

Table 7: Socio-demographic characteristics of women aged 15-49 in ASSP provinces, ASSP baseline DRC 2014

	Nord Ubangi n=638	Kasai/Kasai Central n=635	Maniema/ Tshopo n=712	Overall n=1,985
Setting				
Urban	8.7	15.5	9.5	12.6
Rural	91.3	84.5	90.5	87.4
Age in years				
15-24	37.1	40.3	36.6	38.6
25-34	40.0	36.0	32.9	35.5
35-44	16.9	19.4	21.5	19.7
45-49	6.1	4.3	8.7	6.0
Mean age:	27.8	27.9	29.2	28.3
Education				
No education	41.2	20.3	20.4	23.3
Some primary	33.8	33.6	30.5	32.6
Completed primary	23.4	41.3	45.1	40.0
Secondary or higher	1.3	4.2	3.7	3.6
Wealth quintile				
Low	17.8	32.0	1.8	20.0
Low middle	31.9	16.7	20.0	20.0
Middle	23.9	11.8	33.5	20.7
High middle	17.0	16.0	25.6	19.3
High	9.3	23.5	19.0	20.0
Number of living children				
0	25.2	17.7	20.6	19.8
1-2	31.4	30.9	30.9	31.0
3-4	24.6	25.8	26.2	25.7
5+	18.7	25.6	22.3	23.6
Mean number of children	2.5	3.0	2.7	2.8
Mean number of live children (by age group)				
15-24	0.6	1.0	1.0	1.0
25-34	3.0	3.5	3.1	3.3
35-44	4.5	5.2	4.4	4.8
44-49	4.4	6.3	4.1	5.0

Religion				
No religion	0.0	1.1	0.0	0.6
Catholic	45.1	14.0	25.3	22.2
Protestant	45.6	10.5	31.9	22.6
Kimbanguiste	0.9	1.9	2.9	2.1
Other Christian	7.4	56.9	35.5	42.8
Muslim	0.5	1.3	3.7	2.0
Animist	0.2	2.6	0.0	1.4
Other	0.1	11.7	0.4	6.3
Marital status				
Never married	19.0	12.0	13.5	13.5
Married/in a union	73.0	85.5	75.8	80.5
Divorced/separated/widowed	8.0	2.5	10.4	5.9

% = Weighted percentage; n= Unweighted sample size

C. Knowledge of contraceptive methods

As shown in Table 8, a large majority of women aged 15-49 (87.1%) reported that they had heard of at least one method of pregnancy prevention, and almost as many (82.7%) had heard of a modern method.[13] However, there were important variations by province, with Maniema/Tshopo having higher levels of knowledge than Kasai/Kasai Central or Nord Ubangi on most methods. The male condom was by far the best-known method (among 75.5% of women). In contrast, the least-known methods – by less than one-quarter of respondents– were male sterilization, emergency contraceptives, IUDs, and lactational amenorrhea (LAM).

[13]Modern methods include the pill, implant, injectable, intrauterine device (IUD), male and female condom, female and male sterilization, Standard Days Method/Cyclebeads, LAM, and fertility awareness methods. Traditional methods include rhythm, withdrawal, and other folkloric methods.

Table 8. Knowledge of contraceptive methods of women ages 15-49 in ASSP provinces by socio-demographic characteristics, ASSP baseline DRC 2014

	Nord Ubangi n=638	Kasai/Kasai Central n=635	Maniema/ Tshopo n=712	Overall n=1,985
Knowledge of specific methods				
Male condom	66.6	68.1	91.2	75.5
Withdrawal	33.8	57.9	82.1	62.4
Rhythm/calendar	28.8	48.1	76.8	54.8
Injectable	24.8	38.6	63.9	45.0
Pill	13.7	36.9	64.6	42.7
Female sterilization	28.1	45.2	43.8	42.3
Female condom	13.1	27.9	46.9	32.0
Implants	5.6	24.1	42.6	27.5
LAM	21.9	12	45.7	24.5
IUD	9.1	22.2	23.3	20.7
Emergency contraceptive	4.9	7.2	32.5	15.2
Male sterilization	4.6	12.0	19.9	13.5
None	17.6	15.3	3.5	11.8
Other modern (incl foam)	3.3	4.6	13.6	7.4
Other traditional	2.5	8.2	9.9	8.0
Knowledge of any method	81.2	82.7	96.8	87.1
Knowledge of at least one modern method	78.0	75.6	96.3	82.7
Knowledge of at least one traditional method	47.4	68.1	90.5	72.5

% = Weighted percentage; n= Unweighted sample size

D. Contraceptive use

As shown in Table 9, among women married or in union, 18.2% reported using some type of method to prevent or delay pregnancy: 12.5 % used a traditional method, compared to 5.7 % that used modern contraception. Current use of modern methods was higher in Maniema/Tshopo (12.3%) than in Nord Ubangi (3.3 %), and Kasai/Kasai Central (2.5%). In all three sampling areas, male condoms were the most commonly used modern method (2.5%), followed by female sterilization (0.7%), LAM (0.6%) and pills (0.4%). (Note: in the DRC, female sterilization is often performed for medical reasons; rarely do women request it for contraceptive purposes.)

Table 9. Current use of contraceptive methods among women married or in union, age 15-49 in ASSP provinces by sampling area, ASSP baseline DRC 2014

	Nord Ubangi n=455	Kasai/Kasai Central n=524	Maniema/ Tshopo n=538	Overall n=1517
Percent reporting use of specific methods				
None	95.5	86.2	72.4	83.1
Rhythm/calendar	0.8	7.4	13.9	8.6
Withdraw	0.5	3.9	1.5	2.7
Male condom	0.2	0.5	7.0	2.5
Fem sterilization	0.9	0.0	1.9	0.7
LAM	1.7	0.0	1.1	0.6
Pill	0.0	0.5	0.2	0.4
Implants	0.0	0.0	1.2	0.4
Injectable	0.4	0.0	0.1	0.1
Female Condom	0.0	0.1	0.1	0.1
IUD	0.0	0.0	0.1	0.0
Other modern	0.0	1.3	0.1	0.8
Other traditional	0.0	0.0	0.3	0.1
Use traditional method	1.5	11.8	18.4	12.5
Use modern method	3.3	2.5	12.3	5.7

% = Weighted percentage; n= Unweighted sample size

E. Unmet need

Unmet need for FP is defined as the percentage of sexually active, fecund women 15-49 years old who have no desire for more children or would like to postpone their next pregnancy by at least two years, but are not currently using any contraceptive method. Overall, 21.2% of women had an unmet need for FP: 17.9% for spacing and 3.3% for limiting. The level of unmet need for limiting was similar over the three sampling areas, ranging from 2.5-4.4%. By contrast, unmet for spacing ranged from 11.9% to 24.6%; it was by far the highest in Nord Ubangi and lowest in Maniema/Tshopo (see Table 10).

Table 10. Unmet need among women ages 15-49 in ASSP provinces by sampling area, ASSP baseline DRC 2014

	Nord Ubangi n=638	Kasai/Kasai Central n=635	Maniema/ Tshopo n=712	Overall n=1, 985
Unmet need for family planning				
Unmet need for spacing	24.6	19.7	11.9	17.9
Unmet need for limiting	3.6	2.5	4.4	3.3
Using for spacing	2.6	10.6	23.5	13.7
Using for limiting	1.7	1.4	3.4	2.1
No unmet need	43.6	42.8	35.9	40.7
Infecund or menopausal	6.2	11.4	7.6	9.4

% = Weighted percentage; n= Unweighted sample size

F. Correlates of modern contraceptive use

As shown in Table 11, we conducted a bivariate analysis to test the association of different socio-demographic factors with modern contraceptive use among women married or in union aged 15-49. The independent variables were age, level of education, religion, level of wealth quintile, and geographic region of residence (sampling area). The bivariate relationship was significant for education (p=0.0013), wealth quintile (p=0.0004), and geographic region of residence (p=0.0001). As a further analysis, the association of modern contraceptive with the education and wealth quintile was tested separately for each geographic region (sampling area). Results showed that the relationship between education and modern contraceptive use was significant for the study population as a whole, because of the highly significant relationship in Kasai/Kasai Central. Similarly, the association between modern contraceptive use and wealth quintile was significant for the entire study population, due to a highly significant association in Maniema/Tshopo.

Table 11. Bivariate analysis of the association between socio-demographic characteristics and modern contraceptive use among women married or in union aged 15-49 in ASSP provinces, ASSP baseline 2014

	mCPR	P-value
Age		0.4877
15-24	4.2	
25-34	5.5	
35-44	6.8	
45-49	10.5	
Education		0.0013
No education	5.1	
Some primary	3.0	
Completed primary	6.5	
Secondary or higher	26.4	
Religion		0.5156
Catholic	7.9	
Protestant	4.8	
Other Christian	5.3	
Other	4.4	
Wealth quintile		0.0004
Lowest	2.5	
Lower	2.8	
Middle	3.0	
Higher	13.2	
Highest	7.0	
Domain		0.0001
Nord Ubangi	3.3	
Kasai/Kasai Central	2.5	
Maniema/Tshopo	12.4	

Table 12 presents results from a multivariate analysis that used the same five socio-demographic factors as independent variables and modern contraceptive use as the dependent variable. Multiple logistic regressions yielded the marginal effect of each independent variable on modern contraceptive use. As shown in Table 12, age and religion had no significant association with modern contraceptive use. By contrast, women with a secondary or higher education were more likely (by 20 percentage points) than women with no education to use modern contraception. Also women in the highest wealth quintile were more likely (by 5.2 percentage points) to use modern contraceptive methods compared to those at the lowest level.

Table 12. Multivariate analysis of the association of socio-demographic factors and modern contraceptive use among women married or in union aged 15-49 in ASSP provinces, ASSP baseline 2014

	Marginal effect	Standard error	p-value

Age			
15-24	Reference		
25-34	0.008	0.015	0.603
35-44	0.011	0.022	0.625
45-49	0.040	0.050	0.419
Education			
No education	Reference		
Some primary	-0.021	0.021	0.316
Completed primary	0.000	0.024	0.988
Secondary or higher	0.199	0.068	0.003
Religion			
Other	Reference		
Catholic	-0.018	0.061	0.775
Protestant	-0.046	0.055	0.397
Other Christian	-0.025	0.051	0.619
Kimbanguiste	-0.001	0.074	0.987
Muslim	-0.010	0.061	0.871
Wealth quintile			
Lowest	Reference		
Lower	-0.022	0.026	0.405
Middle	-0.031	0.025	0.200
Higher	0.052	0.023	0.028
Highest	0.008	0.027	0.759
Domain			
Nord Ubangi	Reference		
Kasai/Kasai Central	-0.027	0.017	0.120
Maniema/Tshopo	0.073847	0.023215	0.001

G. Placing family planning in the ASSP-supported health zones into the larger national context

Fortuitously, in the same year as the ASSP baseline, the Demographic and Health Survey (DHS) was conducted for the country as a whole. The DHS is considered the gold standard for health-

related survey research in developing countries, and as such, it allows us to put the ASSP findings in the context of results obtained from the DHS for the same provinces. Given differences in sampling, the two data sets are not strictly comparable. The DHS yielded data representative at the provincial level for each the provinces in the DRC.[14] By contrast, the ASSP data is representative of the catchment areas for the project. In Table 13, we present findings on selected FP variables from:

- The ASSP baseline
- The 2013-14 DHS, rural areas of the same provinces as the ASSP baseline
- The 2013-14 DHS,[15] entire country.

Table 13. Comparison of ASSP baseline data with the 2013-14 DHS data for women 15-49 years old on selected family planning variables

	ASSP baseline	2013-14 DHS (rural areas of same provinces)	2013-14 DHS (entire country)
% know one or more modern methods	82.7	82.3	88.1
Contraceptive use (married or in union)			
Modern	5.7	5.4	8.1
Traditional	11.3	11.1	11.1
Any method	15.8	16.5	19.3
Unmet need (all women)			
Spacing	17.9	17.8	15.6
Limiting	3.3	5.4	4.4
Total	21.1	23.2	20.0
% of all modern users (married or in union) relying on condoms	51.7	55.2	56.5

Although the sampling was different for the ASSP baseline and the DHS 2013-14 survey (in rural areas of the same provinces), the findings are strikingly similar on the FP variables presented in Table 14, lending further face validity to the values obtained from the ASSP baseline. The data from the ASSP baseline tended to be slightly lower than the DHS 2013-14 data for the entire

[14] It is not possible to obtain DHS data that are specific to the ASSP-supported health zones, since the purpose of the DHS survey and sampling procedures are totally different.

[15] Ministère du Plan et Suivi de la Mise en œuvre de la Révolution de la Modernité (MPSMRM); Ministère de la Santé Publique (MSP); ICF International. Enquête Démographique et de Santé en République Démocratique du Congo 2013-2014. Rockville (MD): MPSMRM; 2014. Co-published by MSP and ICF International. Available from: http://dhsprogram.com/pubs/pdf/FR300/FR300.pdf

country (shown in the third column), which is not surprising since the latter includes major urban areas. Yet it is noteworthy that the areas selected for the ASSP baseline are in fact as consistent as they are with national trends, reflecting low levels of contraceptive use across the country.

H. Summary overview of the status family planning in ASSP-supported areas at the start of the project

This brief summary provides a profile of the women in the catchment area for the ASSP interventions in terms of socio-demographic characteristics and FP use at the start of the ASSP project. The population is largely rural (87.4%). Less than 5% of women had completed high school. By age 45-49, women in this population had an average of 5.0 children.

The large majority of women had heard of at least one method for preventing pregnancy. At the start of the project 18.2% of women married or in union used some means of preventing pregnancy: 12.5% a traditional method and 5.7% a modern method. More than half of all modern users relied on male condoms, possibly because of limited access to a fuller range of contraceptives. Use of a modern method was higher among women who were in higher wealth quintiles and had secondary education or more.

Unmet need was 21.2%, which by global standards is relatively high but not extreme. (By comparison, unmet need in Kinshasa is 31.3%). One could interpret this 21.2% to reflect a felt need on the part of many women in this population for a means of pregnancy prevention; yet for a sizable number, high parity is not perceived as problematic. Only 3.3% of women had an unmet need for limiting.

One notable trend in the baseline data was higher knowledge of and use of modern contraceptive methods among women in Maniema/Tshopo as compared to the two other sampling areas in the ASSP baseline. This difference has been taken into consideration in establishing the CYP targets for the project.

In summary, the ASSP baseline data provides a useful assessment of key family planning dynamics near the beginning of the five-year ASSP project. They will also serve as the baseline against which to measure the impact of the FP intervention under the ASSP project. However, such information will not be available until the final year of ASSP (2018).

VI. Readiness of health facilities to provide FP services

The 2014 baseline included a facility-based survey of health centres in ASSP-supported health zones. (It also included health centres from comparison areas, but these data are excluded from the analysis in this section.)

Data from the facility-based survey reflects the readiness of health facilities to provide different health services. As noted above, 13 of the 52 health zones were continuing service that had started under ATH. By contrast, in 39 of the 52 health zones activities began in March 2014, which coincides with the baseline survey. Therefore the data provides valuable insights into the status of FP services near the start of the program.

In this section we present the data on FP from two perspectives: how close are the findings to the ideal (which would be 100% on most variables) and how do the findings for FP compare with those for other health interventions? For example, if only 10% of the facilities sampled have "X contraceptive" in stock, this number falls far short of the ideal 100%. If only 10% of facilities have the similar item (e.g., drug for malaria), the problem appears to be generic to the facility. By contrast, if 50% of facilities have the drug for malaria, but only 10% have contraceptives, this implies that the shortcoming is specific to FP.

The data presented in this section are drawn from the report on the ASSP baseline facility-based survey (Tulane University School of Public Health and Tropical Medicine & University of Kinshasa School of Public Health, 2014). We include most of the variables relevant to FP service delivery, as well as selected findings related to other health topics for comparative purposes.

A. Availability of FP commodities and equipment

Table 14 shows the availability of three contraceptive methods by sampling area; for comparative purposes we present two "tracer drugs" used to treat malaria. As of 2014, only 5.8% of facilities had all four contraceptive methods in stock. Condoms were by far the most available, (50.0% of facilities), followed by oral contraceptives (35.6% of facilities), IUDs (18.6%), and implants (17.3%).

The facilities in Maniema/Tshopo were better stocked in all contraceptive methods than were the facilities in Kasai/Kasai Central. Nord Ubangi was the least well-stocked, having condoms in only 32.4% of facilities, oral contraceptives at 3.6%, and implants and IUDs at no facility.

By comparison, the tracer drugs needed to treat malaria were far more available in these same health facilities: 88.5% had ACT and 60.6% had quinine. Curiously, of the three sampling areas, Nord Ubangi was better supplied with malaria drugs than the other two sampling areas (which was just the opposite for contraceptives). The disparity between availability of contraceptive methods

and drugs for malaria treatment indicates that the logistical challenges of getting equipment and supplies into Nord Ubangi are not insurmountable.

Table 14: Availability of contraceptive methods (and for purposes of comparison drugs for malaria treatment) in ASSP sampled facilities by sampling area (2014 ASSP baseline survey)

	Nord Ubangi n=34	Kasai/Kasai -Central n=35	Maniema/ Tshopo n=35	Total n=104
Family Planning (%)				
Condoms	32.4	57.1	60.0	50.0
Oral contraceptives	6.3	42.9	55.9	35.6
IUD	5.9	25.7	24.2	18.6
Implant	0.0	20.0	31.4	17.3
All four contraceptives	0.0	14.3	5.7	6.7
Malaria treatment (tracer drugs) (%)				
ACT[1]	100.0	88.6	77.1	88.5
Quinine	85.3	65.7	31.4	60.6

[1] ACTs included either: artemether + lumefantrine or artesunate + amodiaquine formulations

Table 15 compares the availability of "all items for family planning" (the four contraceptive methods, as shown in the previous table) to the availability of all items for other key areas in this integrated health project. Facilities were better equipped to deal with malaria (32.7% having "all items") than other diseases/health conditions near the start of the ASSP project. Only 14.4% of facilities had all the basic equipment, only 10.6% had all items for normal delivery, only 3.9% had all items for complicated delivery, and only 1% had all items for infection control. FP fell considerably lower than malaria, but was similar to other areas that lacked items needed to deliver services near the start of the ASSP project.

Table 15: Percentage of sampled health facilities in ASSP areas with "all items available" (equipment, supplies, and drugs) for key health problems, by sampling area (2014 ASSP baseline survey)

	Nord Ubangi n=34	Kasai/Kasai-Central n=35	Maniema/ Tshopo n=35	Total n=104
Equipment, supplies, drugs				
All basic equipment	5.9	5.7	31.4	14.4
All items for infection control	0.0	2.9	0.0	1.0
All items for malaria diagnosis and treatment	50.0	28.6	20.0	32.7
All items for a normal delivery	5.9	14.3	11.4	10.6
All items for a complicated delivery	0.0	11.4	0.0	3.9
All three contraceptive methods (condoms, oral contraceptives, IUD)	2.9	25.7	14.3	14.4

B. Delivery of health services

Table 16 presents data on the percentage of facilities in ASSP-supported areas that offered different health services as of 2014. Close to three quarters (73.8%) reported offering community based outreach services, whereas two thirds (68.3%) offered treatment of sexually transmitted infections. In terms of maternal and child health, virtually all health facilities (>95%) offered antenatal care, immunizations, postnatal care, and normal delivery care. By contrast, only 60.6% offered FP services. The availability of FP varied greatly by sampling area, ranging from a high of 97.1% in Maniema/Tshopo to a low of 35.3% in Nord Ubangi.

Despite the absence of contraceptives in some facilities, over three quarters (76.9%) of facilities gave FP counseling during postnatal services. However this practice was far more common in Maniema/Tshopo than in Kasai/Kasai Central. Facilities were more likely to counsel on conventional topics during postnatal services – hygiene counseling for mother and child, breast-feeding, newborn checkup and treatment, growth monitoring and promotion, mother's checkup and treatment – than on FP in all sampling areas.

Table 16: Percent of health facilities in ASSP supported areas that report to provide different health services, by sampling area (2014 ASSP baseline survey)

	Nord Ubangi n=34	Kasai, Kasai-Central n=35	Maniema/ Tshopo n=35	Total n=104
General services (%)				
Community-based outreach services	82.5	68.6	70.6	73.8
Treatment of sexually transmitted infections	73.5	40.0	91.4	68.3
Maternal and Child Health (%)				
Antenatal care	100.0	100.0	100.0	100.0
Immunizations	100.0	97.1	100.0	99.0
Post-natal care	100.0	94.3	100.0	98.1
Normal delivery	91.2	94.3	100.0	95.2
Family planning	35.3	48.6	97.1	60.6
C section delivery	8.8	8.6	22.9	13.5
Components of care offered during postnatal services (%)				
Hygiene counselling for mother and child	88.2	82.9	97.1	89.4
Breastfeeding counselling service	85.3	82.9	97.1	88.5
Newborn check-up and treatment	88.2	77.1	97.1	87.5
Growth monitoring and promotion	88.2	80.0	94.3	87.5
Mother's check-up and treatment	85.3	74.3	94.3	84.6
Nutrition counselling for breastfeeding mothers	85.3	68.6	97.1	83.7
Family planning counselling	76.5	57.1	97.1	76.9

Table 17 indicates the cost to clients for different services (based on the number of facilities that offered each service). Family planning clustered with three other services (postnatal care, treatment of TB, and immunization) that were offered free of charge in the vast majority of facilities (if they were available at all). By contrast, at least half of facilities charged some fee for antenatal care (on average $1.85), close to one quarter charged for C-section delivery ($44.78), and one-fifth charged for treating sexually transmitted infections ($3.02). Almost all facilities charged for normal delivery: $3.28 on average., As of 2014, facilities were adhering to the mandate of providing contraceptives free of charge to the population.

Table 17: Percentage of sampled health facilities in ASSP areas offering specified services for free and (of those charging a fee) the mean fee and range (2014 ASSP Baseline Survey)

	Overall fees		
Services offered	**Free (%)**	**Mean, min and max cost if not free (USD)**	**Facilities offering the service (n)**
Post-natal care	98.0	0.56 [no range]	101
Treatment of tuberculosis	97.7	2.22 [no range]	44
Immunization	94.2	2.11 [0.56, 3.89]	104
Family planning	93.7	1.89 [0.33, 3.33]	63
Antenatal care	52.9	1.85 [0.11, 55.56]	104
C-section delivery	23.1	44.78 [3.89, 77.78]	14
Treatment of STI	19.7	3.02 [1.33, 7.78]	71
Normal delivery*	1.0	3.28 [0.22, 12.50*]	99

*For normal deliveries, two outliers were removed - $333 and $500

The data provided in the p three tables came from observation of products in stock or interviews with the person responsible for the health centre. By contrast, the data in Table 18 reflects responses from health workers in the sampled facilities. Of those interviewed for this survey, 50% of health care workers reported that they provided FP services. Consistent with the previous tables, the highest percentage of health workers providing FP was in Maniema/Tshopo (58.1%), followed by 43.9% in the Kasais, and 41.5% in Nord Ubangi. Maniema/Tshopo emerges from the baseline survey (both in terms of contraceptive prevalence rate and availability of contraceptives) as the

champion of FP service provision, but interestingly, it does not have the highest percentage of service provision for many other important health issues such as TB treatment/diagnosis and vaccinations.

Table 18: Services that health workers in sampled health facilities in ASSP areas reported to have provided within the past 3 months (2014 ASSP baseline survey)

Services provided	Nord Ubangi n=53	Kasai, Kasai-Central n=82	Maniema, Tshopo n=117	Overall n=252
Malaria treatment	98.1	87.8	86.3	89.3
Vaccinations	98.1	86.6	74.1	83.2
Antenatal care (ANC)	100.0	79.3	70.9	79.8
Deliveries in a facility	90.6	76.8	67.5	75.4
Supervision of Community Health Workers	71.7	40.2	25.0	39.8
Postnatal care (PNC)	86.8	69.5	56.9	67.3
Other outreach services	90.6	63.4	52.1	63.9
Family planning (temporary and permanent methods)	41.5	43.9	58.1	50.0
Nutrition (growth monitoring, nutrition counselling, etc.)	67.9	35.4	50.4	49.2
Inpatient care/services	26.4	37.8	65.8	48.4
Community Health Worker training	66.0	30.5	12.1	29.5
Major surgery	3.8	4.9	7.7	6.0
Tuberculosis treatment/diagnosis	28.3	20.7	17.1	20.6
Home deliveries	3.8	4.9	6.0	5.2
Other	24.5	29.3	22.2	25.0

VII. Inputs for the FP component of the ASSP Project

In assessing the FP component of the ASSP Project, it is important to document the actual inputs, labeled "support to service delivery" in the theory of change; Figure 1 explicitly cites training, supervision, and resources. In this section we describe the inputs to the FP component of ASSP, consistent with the seven priority pillars as defined by the DRC government's PNDS 2011-2015. The priority pillars include service delivery, human resources for health, medications and specific inputs, infrastructure and equipment, health information systems, health financing, and governance (Ministère de la Santé Publique, 2010).

Service delivery

ASSP-supported facilities include 55 general reference hospitals, 144 reference health centres and 803 health centres (see Table 7 for number and type of facility by province). Among other services listed in the government's minimum package of services, all ASSP-supported facilities are expected to provide FP counseling from a trained provider and offer a range of contraceptive methods.

In addition to facility-based FP services, ASSP supports the community-based distribution of the pill, condoms, and Cyclebeads. If a woman is interested in a longer-acting method, a trained community distributor will refer her to the nearest health centre offering FP services.

Human resources for health

In order to ensure providers are competent to provide FP services, ASSP trained 64 national level "master trainers," which included experts from the *10ème Direction*, PNSR, Roi Baudouin Hospital, and other hospitals and maternity clinics in Kinshasa, the Centre de Formation en Santé de la Reproduction Aboubakar Touré, as well as the MCH focal point from each ASSP Implementing Partner. In turn, these master trainers were responsible for conducting 14-day trainings at the provincial and health zone level, covering RH topics such as family planning, post abortion care, and the provision of post-exposure prophylaxis (PEP) kits and emergency contraceptives to survivors of sexual violence. By the end of Year 2 of the project, ASSP had trained 104 provincial staff from the various *Division Provinciale de la Santé* (Provincial Health Division [DPS]) offices and the provincial PNSR offices, 115 health zone officials including MCZs and 2-3 clinical experts from each ASSP-supported health zone, and 1,105 front line health care providers (see Table 19 for specific numbers by province). During Year 3 of the project, ASSP provided a 3-5 day refresher training to 79 health zone officials and 322 health care providers.

In addition, by the end of Year 3 of the project, ASSP had trained 155 health zone officials, 580 health care providers, and 3,479 community health workers (*relais communitaires*) on the community based distribution of contraceptives. These individuals were trained to provide

education on the various family planning methods using standardized guides, images and other communication materials, as well as distribute contraceptive methods at the community level.

Medications and specific inputs/ Infrastructure and equipment

In addition to training service providers, supplying health zones with the necessary FP commodities is a priority for ASSP. Table 19 provides a full list of contraceptives supplied by the project and the quantity of specific contraceptives distributed to facilities since the start of ASSP. ASSP also provided health facilities with basic RH equipment including scales, blood pressure monitors, gynecological tables, and standard instruments used for gynecological exams, and provided specialized surgical equipment to 14 general reference hospitals.

Health information system

In order to improve the availability of health data in the DRC, ASSP is assisting the government in revising and harmonizing the SNIS tools as well as implementing a web-based system for reporting the SNIS data, known as the DHIS 2. ASSP has provided training on the new SNIS tools and the use of DHIS 2 in all ASSP-supported health zones in Kasai, Kasai-Central, Maniema, and Nord Ubangi. The Global Fund has provided a similar training for ASSP-supported HZs in Tshopo. Although the DHIS 2 is currently operational, the completeness and quality of the data varies from structure to structure and from one HZ to another. Improving the quality and completeness of data reporting to the DHIS 2 continues to be an ASSP priority in the remaining two years of the project. As noted above, in the meantime ASSP is using a combination of DHIS 2 data and data from paper copies of the SNIS reports entered into an excel sheet by the IPs in order to report on service statistics, including FP statistics.

Health financing

ASSP provides all FP services and methods free of charge. There is no expectation of cost recovery from user fees. Whereas the DRC government contributes the salaries and health facilities/warehouses for this project, the donor (DFID) finances the entire cost of contraceptives.

Governance

Governance is a cross cutting pillar of health systems strengthening. As ASSP is an integrated program, all efforts made to strengthen leadership/governance of the health system also have an impact on FP programs. At the local level, ASSP is working with the local *Comité de Développement de l'aire de Santé* (CODESA), or the Development and Health Committee, to strength the local governance systems. In addition to the numerous activities for which CODESAs are responsible, committee members are trained as community based distributors of FP methods and are active in in FP advocacy with the local population. Moreover, ASSP has set up a community scorecard program whereby communities are able to voice their opinions and concerns regarding the provision of health services. While FP is not a specific focus of the scorecard process,

women have already take the opportunity to discuss FP services, such as expressing the need for privacy and confidentially when seeking FP counselling.

At the national level, ASSP participated in the development of the National Multisectoral Strategic Plan for Family Planning: 2014 – 2020 and has helped the country to effectively quantify their needs for contraceptive methods. This has included ensuring that FP commodities are included in HZ and health facility order forms for procurement. This has allowed for the integration of FP commodities in the medicine supply chain system.

Table 19. Summary of ASSP Family Planning Activities by Health Systems Pillar

Health Systems Pillar	ASSP Family Planning Activities
Service Delivery	ASSP provides support to 1,002 facilities, including: • **Kasai:** 17 general reference hospitals, 48 reference health centres, and 316 health centres • **Kasai-Central:** 10 general reference hospitals, 25 reference health centres, and 126 health centres • **Nord Ubangi:** 11 general reference hospitals, 25 reference health centres, and 144 health centres • **Maniema:** 10 general reference hospitals, 31 reference health centres, and 113 health centres • **Tshopo:** 3 general reference hospitals, 6 reference health centres, and 48 health centres • **Sud Kivu:** 4 general reference hospitals, 9 reference health centres, and 56 health centres All ASSP supported facilities have a trained provider in FP and offer FP methods. ASSP also supports community-based distribution of the pill, condoms, and Cyclebeads.
Human Resources for Health	As of Quarter 8 (Year 2), ASSP has trained the following personnel in FP: • **National:** 64 "master trainers" • **DPS:** 104 provincial MOH staff • **Kasai and Kasai-Central:** 41 health zone staff and 569 health workers • **Nord Ubangi:** 15 health zone staff and 224 health workers • **Maniema/Tshopo:** 59 health zone staff and 235 health workers • **Sud Kivu:** 79 health workers All trainings are 14 days and cover FP, post abortion care, and the provision of PEP kits and emergency contraceptives to survivors of sexual violence. As of Quarter 11 (Year 3), ASSP has provided a 3-5 day refresher course to the following personnel: • **Kasai and Kasai-Central:** 22 HZ staff and 187 health workers • **Nord Ubangi:** 3 HZ staff and 69 health workers • **Maniema/Tshopo:** 50 HZ staff and 28 health workers

	• **Sud Kivu:** 4 health zone staff and 38 health workers As of Quarter 11 (Year 3), ASSP has provided training on the community based distribution of contraceptives to the following personnel: • **Kasai and Kasai-Central:** 28 HZ staff, 521 health workers and 2,693 community health workers • **Nord Ubangi:** 45 health workers and 201 community health workers • **Maniema/Tshopo:** 110 HZ staff, 14 health workers and 560 community health workers • **Sud Kivu:** no trainings
Medications and specific inputs/ Infrastructure and equipment	As of Quarter 11 (Year 3), ASSP has supplied the following FP contraceptives to supported HZs: • Cycle beads: 19,750 • IUD: 29,516 • Implanon NXT: 70,320 • Implanon: 76,512 • Norvelo: 9,862 • Microgynon: 326,914 • Mucrolut: 348,171 • Postinor: 9,835 • Syana Press: 57,800 • Depo-Provera: 260,308 • Noristerat: 22,052 • Female condoms: 1,415,000 • Male condoms: 4,551,206 • Jadelle + Trocar: 5,800 The basic RH equipment provided by ASSP to all health facilities include: • Scale • Blood pressure monitor • Gynecological table • Standard instruments used for gynecological exams

	ASSP also provides specialized surgical FP methods/equipment for 14 selected general reference hospitals.
Information Systems	DHIS 2 training, including training on the collection of FP service statistics, have occurred as follows: • ASSP has provided training for personnel in all 49 HZs in Kasai, Kasai-Central, Maniema and Nord Ubangi • Global Fund has provided training for personnel in all 3 ASSP supported HZd in Tshopo While DHIS 2 is operational in all 52 ASSP-supported HZs (not including Sud Kivu), the level of data completeness and the data quality varies. Therefore ASSP, through the IPs, is also receiving the hard copies of the SNIS reports to be used for verification when the DHIS 2 is not complete.
Health Financing	ASSP provides all FP methods and services are provided free of charge. There is no expectation of cost recovery from user fees
Governance	At the local level, CODESA members are trained as community based distributors and are active in FP advocacy work with the local population. Additionally, ASSP facilitates a community scorecard program, whereby communities are able to voice their options and concerns regarding the provision of health services, including FP services. At the national level, ASSP participated in the development of the National Multisectoral Strategic Plan for Family Planning: 2014-2020 and has helped the country to effectively quantify their needs for contraceptive methods.

Demand creation/BCC

ASSP also supports demand creation activities to increase contraceptive use through community-based distributors who are trained in behaviour change communication strategies. Additionally, while the original plan was to contract with Development Media International (DMI) for the production of radio programming to encourage FP use, the model is now that the IPs are responsible for organizing demand creation activities and BCC campaigns as needed and as appropriate in their project pools.

Challenges within ASSP's FP strategy

Although ASSP has shown to have many promising results, the major challenges of the project identified in Pathfinder's quarterly reports include: (1) strengthening the supply chain and assisting with procurement of FP and RH supplies, (2) gathering reliable data to track performance, and (3) aligning priorities with the MOH continue to be major challenges for the project.

During Year 1 of the project, IMA World Health and the principal investigator of ASSP worked to create lists of RH service commodities available and forecasts for future contraceptive needs. ASSP initiated a partnership with UNFPA, which led to the donation of thousands of contraceptives (Pathfinder International, 2015a). At the end of the Quarter 8 of Year 2, UNFPA donated $171,954.70 worth of progesterone-only contraceptive pills, IUDs, emergency contraceptive pills, and injectables. ASSP has also received a loan from USAID to cover the rest of the contraceptive costs (Pathfinder International, 2015b).

Contraceptives are meant to be distributed from the regional distribution centre of essential medicines, but often are not. Substantial stockouts are commonplace in ASSP-supported health centres. The lack of accurate supply chain records, a coherent logistics system, and the absence of forecasting and ordering contribute to the lack of progress (Pathfinder International, 2015a,b).

As of September 2014, FP activities were not fully operational in most of the new HZs, especially in Nord Ubangi. Field visits in the province showed that some of the health zones had not received any family planning materials, even though there was a distribution plan in place. In many other health zones, only the general referral hospitals had been supplied with contraceptives (Pathfinder International, 2014). By the end of the Quarter 11 of Year 3, the logistics management information system was still not fully functional. The information that was obtained was of poor quality due to missing and incomplete data (Pathfinder International, 2015b).

In addition to supply chain difficulties, the lack of complete and timely program monitoring data made it difficult to track progress and understand trends in the first two years of the project. Data was not disaggregated by age, which made it difficult to monitor the characteristics of the users (percent that were less than 20 years old). Training providers and provincial MOH staff on new SNIS forms as well as the DHIS 2 is helping to improve the quality of data, as seen in Year 3.

Lastly, conflicts in agendas and differing priorities between the project and the MOH at the central and provincial levels are causing delays in FP activities. The same MOH personnel are involved in all ASSP activities (WASH, nutrition, RH, etc.), causing non-compliance to FP timelines. While the project continues to re-negotiate the timing of activities, problems persist into Year 3.

VIII. FP performance as measured by CYP and new acceptors

A. Importance of output indicators for measuring FP performance

Performance in family planning programs in developing countries is generally measured in two ways: in terms of the outputs produced by the program (measured at the program level with routine service statistics) and by the outcomes (measured at the population level through population-based surveys). In the ASSP project the two outputs of interest are couple-years of protection (CYP) and new acceptors. Routine service statistics can be reported on a monthly, quarterly, and annual basis; thus, in near real-time service statistics are able to provide evidence of progress (or lack thereof) in achieving the project objectives, in this case vis-à-vis family planning.

If a project is doing well, output indicators provide concrete evidence of progress. If a project is not progressing as expected, output indicators can signal a need for midcourse correction. In the case of ASSP, DFID specified in its contract with IMA that if the project did not meet its CYP targets by Year 3 of the project, then IMA should reprogram its funding to improve performance in the area of family planning. **Thus, the extent to which the ASSP project has achieved, exceeded, or fallen short of its CYP targets is of particular importance in this project**.

In terms of FP program evaluation, many in this field would consider the more important indicator to be the modern contraceptive prevalence rate or mCPR (i.e., the percentage of women of reproductive age in the catchment area using a modern contraceptive method). However, this population-based outcome is only available through survey data, which in the case of ASSP were collected at baseline in 2014 and will be collected at endline in 2017. For this reason, output data provide us with the best assessment available on FP progress to date in the ASSP project.

B. Source of data for FP output indicators

To track progress under the ASSP Project, IMA set up a health information system to collect and monitor routine service statistics relevant to the objectives of the project, including family planning. Although IMA is working to strengthen the National Health Information System (Système National d'Information Sanitaire, or SNIS) to be able to obtain its routine monitoring data from it, in the meantime it has set up and uses a parallel system of data collection to ensure full reporting from all participating facilities. IMA is responsible for obtaining the data, which it then makes available to Pathfinder for reporting purposes. IMA provided the same data set to Tulane for the purpose of this analysis. Specifically, it consisted of the raw data available as of December 31, 2015, for the first 11 quarters of the project[16] (April 2013-December 2015) on the number of contraceptives and the number of new acceptors distributed in the 56 health zones served by ASSP.

C. Targets and results for CYP

[16] The ASSP Project uses the designation of Y1Q1 to indicate the first quarter of Year 1. In the current analysis, we have numbered the quarters sequentially from 1 to 11 (April 2013-December 2015).

1. Definition of the indicator: CYP

CYP is the estimated protection provided by contraceptive methods for a one-year period, based upon the volume of all contraceptives sold or distributed free of charge to clients during that period. CYP is calculated by multiplying the number of each type of contraceptive sold or distributed free of charge by a conversion factor, to generate an estimate of contraceptive protection by unit of each method. CYP represents a measure of output ("the volume of contraception dispensed to clients"), which can be reported for a single health facility or aggregated to the district, provincial, or national level. CYP is useful for comparisons between different units (facilities, districts, provinces) and for analyses over time (by quarter or by year). It is also possible to calculate the percentage of all contraceptive use corresponding to each method ("method mix"), although this measure gives greater weight to long-acting methods. Another limitation of CYP is that it is a "numerator" indicator only; it does not provide a measure of coverage (in contrast to mCPR, which does).

2. Preliminary analysis of CYP in ASSP project

In preparation for this case study, Tulane obtained from IMA the raw data (service statistics) required for calculating CYP. In attempting to replicate the numbers produced in the Pathfinder quarterly reports based on the same data, Tulane identified an issue with the conversion factors. Specifically, IMA/Pathfinder had adopted the conversion factors recommended by the SNIS; however, they differed from the widely accepted CYP conversion factors in use among donor agencies and international NGOs at the global level (available on the USAID website) with regard to six methods (as shown in table 20). The following three discrepancies most directly distorted the ASSP data:

- The implant: the national default value given by SNIS was for Jadelle (3.8), whereas the ASSP project primarily provided Implanon, which has a lower factor (2.5);
- LAM: instead of 0.25, the SNIS listed a factor of 2.0, which was eight times higher than the correct value (and in fact is impossible, given the criteria required to be counted as a LAM user); and
- Standard day's method/cycle beads: the SNIS used a factor of 2.0 whereas the global convention is 1.5.

Table 20. Comparison of CYP conversion factors used by SNIS/Pathfinder and USAID (considered the global standard)

Method	SNIS conversion factors	USAID conversion factors	Consistent?
Injectables	0.25	0.25	yes
Pill	0.067	0.067	yes
Mini-pill	0.067	0.067	yes
IUD	4.6	4.6	yes
Implant	3.8	2.5	no
Male condom	0.008	0.008	yes
Female condom	0.008	0.008	yes
Spermicide (tablets)	0.008	0.008	yes
Female sterilization	12.5	10	no
Male sterilization	12.5	10	no
Method auto-observation (MAO)	2	1.5	no
Cyclebeads (Standard Days Method)	2	1.5	no
LAM	2	0.25	no

These small discrepancies in CYP conversion factors had important programmatic implications. Specifically, in its quarterly reported dated May 2015,[17] Pathfinder reported that it had achieved 95% of its CYP target. However, if the globally accepted conversion factors were applied, the program had achieved only 55% of its CYP target.[18]

IMA/Pathfinder took the position that it would adhere to the conversion factors issued by SNIS, until they were corrected. However, in October 2015 SNIS indicated its intention to use the corrected factors starting in 2016. Thus, to be consistent with the SNIS and in consultation with DFID, IMA/Pathfinder adopted the corrected CYP conversion factors. Also, in consultation with DFID, IMA/Pathfinder decided to revisit the CYP targets that had been established at the start of the project.

3. Methodology for establishing new CYP targets

IMA/Pathfinder provided Tulane with the numbers used in developing the original CYP targets for the ASSP project. It became evident that they were based on extrapolations from historical

[17] Pathfinder International (May 2015). DFID ASSP Project. Accès aux Soins de Santé Primaires. Family Planning and Reproductive Health Sub-project Report, January-March 2015.

[18] Bertrand, JT and S Babazadeh, 2015, "Analysis of Trends in Couple-Years of Protection (CYP) in 56 ASSP-funded Health Zones in the Democratic Republic of the Congo (DRC). Tulane School of Public Health and Tropical Medicine, New Orleans, LA; unpublished working paper.

trends from previous projects and data from the MICS 2010 (which in retrospect has produced inconsistent estimates of mCPR when compared to other surveys for the DRC such as DHS and PMA2020).

In view of this situation, Tulane recommended the use of SPECTRUM, a software package that allows for conversion between CYP and mCPR.[19] This software takes into account the following parameters: the baseline level of mCPR, the method mix at baseline (i.e., the distribution of users across different contraceptive methods), the projected annual change in mCPR, the estimated size of the population of women of reproductive age in the catchment areas, and the percentage of the population married or in union. SPECTRUM uses the globally accepted CYP conversion factors.

Table 21. Methodological process for establishing the CYP targets for the ASSP project using SPECTRUM software[20]

1) We entered into the SPECTRUM model the following data from the ASSP baseline survey for each of the three sampling domains. (Note: there was marked variation by domain on several variables):
    a. Contraceptive prevalence rate (all methods)
    b. Method mix
    c. Unmet need
    d. Percentage of women married or in union

2) We used data from the DHS 2013-14 to estimate the total fertility rate (TFR) for each domain (which was not an exact match, since the DHS data was representative of the entire province, whereas the ASSP baseline data was specific to the ASSP-supported HZs):
    a. Nord Ubangi (we used the TFR for Equateur)
    b. Kasai and Kasai Central (we used the TFR for Kasai Occidental)
    c. Maniema/Tshopo (we used the TFR for Maniema, since the majority of HZs [10 of 13] in this sampling domain were in Maniema, and only 3 of 13 were in Tshopo. In the case of Maniema, ASSP operates in almost all HZ; by contrast, ASSP operates in relatively few of the HZ in Tshopo. Thus, Maniema seemed like the better choice.)

3) We entered into SPECTRUM the population of each of the 52 HZs supported by ASSP, based on information provided by IMA.

4) We then estimated the CYP required each year corresponding to a 1 percentage point increase in CPR, with the assumption of no changes in the method mix. The mCPR for the

[19] A description of SPECTRUM is available at http://www.avenirhealth.org/software-spectrum.php

[20] For more complete details, see Bertrand, JT, E Sonneveldt, and S Babazadeh, Feb 2016, "Revising the CYP Targets for the ASSP project," Tulane SPHTM, New Orleans Louisiana. Unpublished working paper.

ASSP-supported HZs was 5.7% in 2014; thus, a 1 percentage point increase per annum would bring the mCPR to 8.7% by the endline in 2017.

5) However, the service statistics for the project indicate the strong uptake in implants as they become available in project-supported HZs. Given the high CYP associated with implants and their apparent popularity, we felt it was important to create alternative scenarios that reflected the extent of implant uptake (which would affect expected levels of CYP):

    a. Scenario #1: no change in the method mix
    b. Scenario #2: 50% of the projected annual growth (of 1 percentage point in CPR) would be contributed by implants
    c. Scenario #3: 100% of the projected annual growth (of 1 percentage point in CPR) would be contributed by implants (this is an extreme case that assumes no change in method mix among current users but all growth in CPR would come from implants).

    Note: Scenario #3 would result in the highest level of CYP (note: sterilization is not a large part of method mix in the population catchment areas).

6) We entered into SPECTRUM the CYP data collected by IMA/Pathfinder for all of the 52 HZs participating in ASSP for 11 quarters (from April 2013 to June 2015), separately for each sampling domain.

7) To determine the extent to which the actual CYP data collected by IMA/Pathfinder aligned with the projected CYP targets established in SPECTRUM, it was necessary to select quarters with the most relevant data for this exercise, given that the baseline survey was conducted in April-May 2014:

    a. For North Ubangi and Maniema/Tshopo, we selected quarters 4-8, which were Jan 2014-March 2015 (because these were the quarters just before, during and just after the ASSP baseline survey)

    b. For Kasai and Kasai Central, we selected Q1-Q5, which covered the period April 2013-June 2014 for the following reason: there was no use of long acting methods in this sampling domain at the time of the baseline survey. If we had followed the same methodology as for the two other sampling domains using Q4-Q8, we would have captured long-acting method use that occurred <u>after</u> the baseline and was resulting in a CYP that was higher than the estimate from SPECTRUM. To state in other terms, it appears from the IMA/Pathfinder service statistics that the provision of long-acting reversible methods (LARCS) was scaled up after the baseline. And once introduced, they were a large contributor to CYP. Thus, in an attempt to find a CYP that corresponded as closely as possible to the method mix found in the baseline survey, we needed to shift and select quarters before the introduction of LARCs; thus we used Q1-Q5.

8) In May 2016 DFID informed IMA, Pathfinder, and Tulane that the expectation of progress for the ASSP project from their headquarters was for a 1.8 percentage point increase per annum in mCPR. For example, a 1.8 percentage point increase per year would take the mCPR from 5.7% at baseline in 2014 to 11.1% at endline in 2017. (All agreed on the assumption that 50% of the projected annual growth would be contributed by implants.) Thus, Tulane used the 1.8 level of increase in generating the CYP targets for the ASSP project.

4. New CYP targets

The CYP targets for the ASSP project generated from SPECTRUM are shown in Table 22, which reflects the assumptions that mCPR will increase by 1.8 percentage points per year over the life of the project and that 50% of the growth will be attributable to the implant. (Because the targets are based on 2014 ASSP baseline data, no target is available for 2013.)

Table 22. CYP targets by sampling domain, assuming a 1.8 percentage point increase in CPR per annum and 50% of growth in CPR corresponds to implants

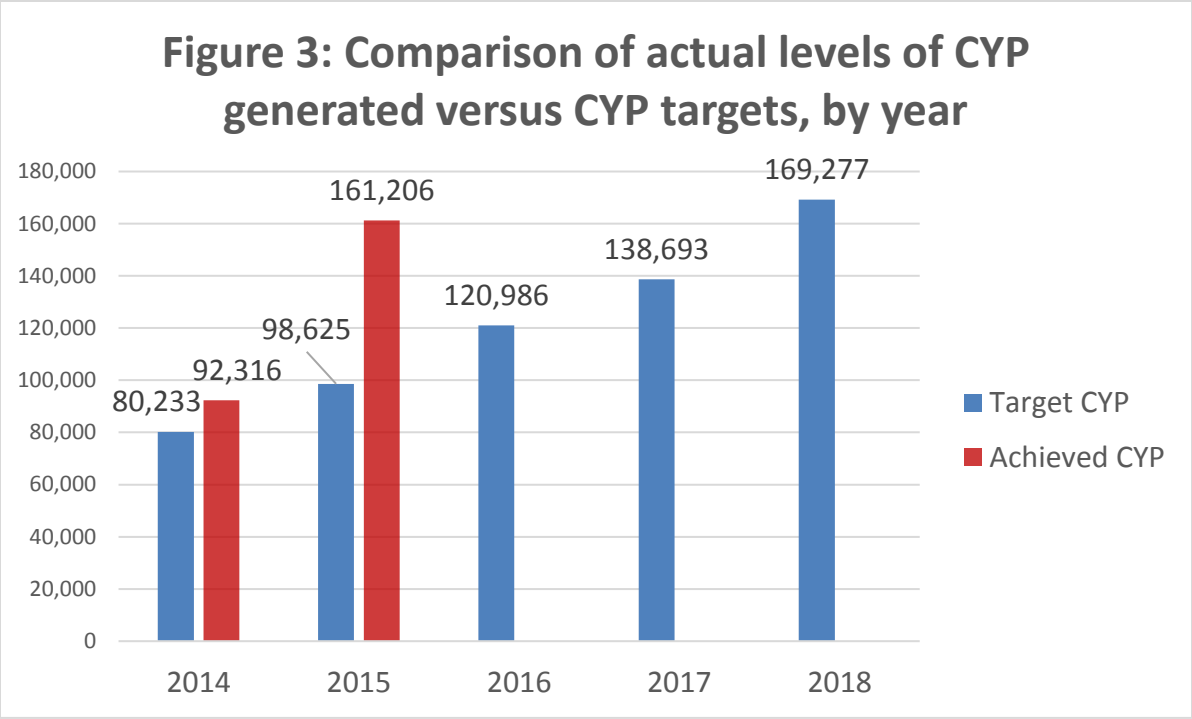
	North Ubangi	Kasai/ Kasai Central	Maniema/ Tshopo	Total	Achieved CYP	Difference
2013	-	-	-	-	15,566	-
2014	15,481	33,770	30,982	80,233	92,316	15%
2015	19,390	45,213	34,022	98,625	161,206	63%
2016	23,523	58,446	39,017	120,986	-	-
2017	28,036	68,358	42,299	138,693	-	-
2018	35,452	86,619	47,206	169,277	-	-

5. ASSP achievement in FP based on new CYP targets

In assessing CYP targets versus achievement over the life of the project, we are not able to include 2013 for lack of a target value that could be generated by SPECTRUM. Rather, we have based this comparison on data from the eight quarters in 2014 and 2015 only.

The results from Table 22 show that the ASSP project has reached and exceeded the CYP targets for 2014 (by 15%) and for 2015 (by 63%). Based on the combined CYP data, ASSP exceeded its target for those two years by 48%.

These same results for 2014 and 2015 appear in graphic form in Figure 3.



In addition to the data on achievement of CYP targets, it is also useful to understand patterns of service utilization. With regard to method mix (the percentage of CYP that corresponds to each modern method), Figure 4-a shows results for the first 11 quarters of the project (data available at the time this report was completed). Figure 4-b presents the breakdown for the most recent quarter (quarter 11 or Y3Q3). The breakdown is surprisingly consistent for the entire project versus the most recent quarter. Over half of CYP is attributable to the implant. Other methods contribute 10 percent or less of the total CYP.

Figure 4-a. Distribution of CYP by method over life of project (April 2013-Dec 2015)

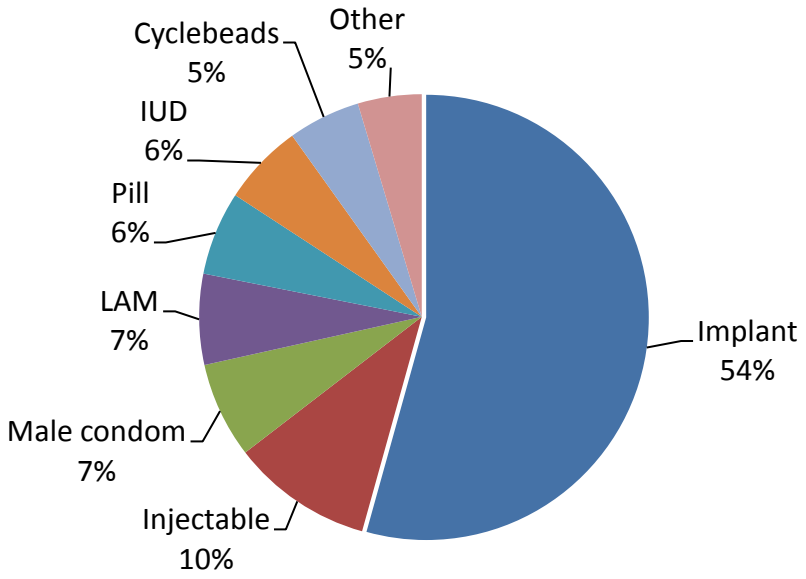


Figure 4-b. Distribution of CYP by method in most recent quarter (Oct-Dec 2015)

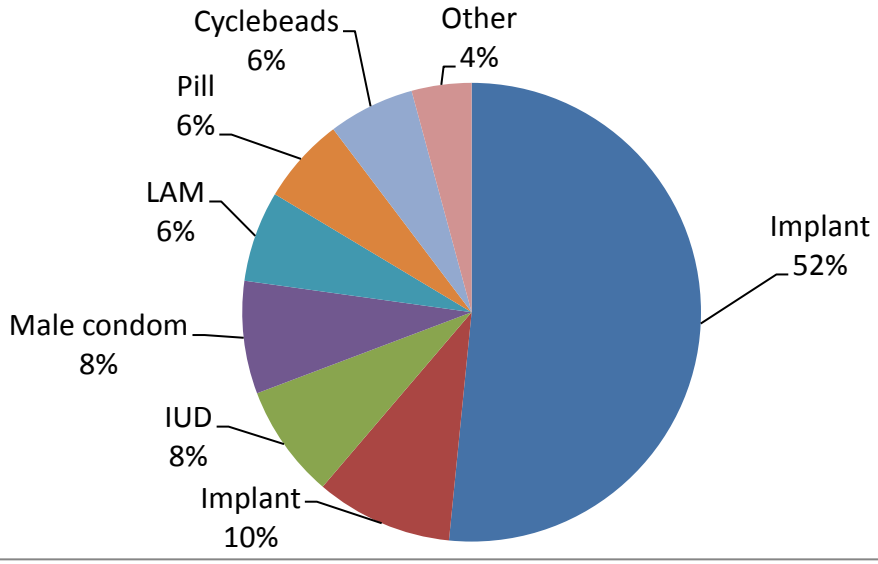
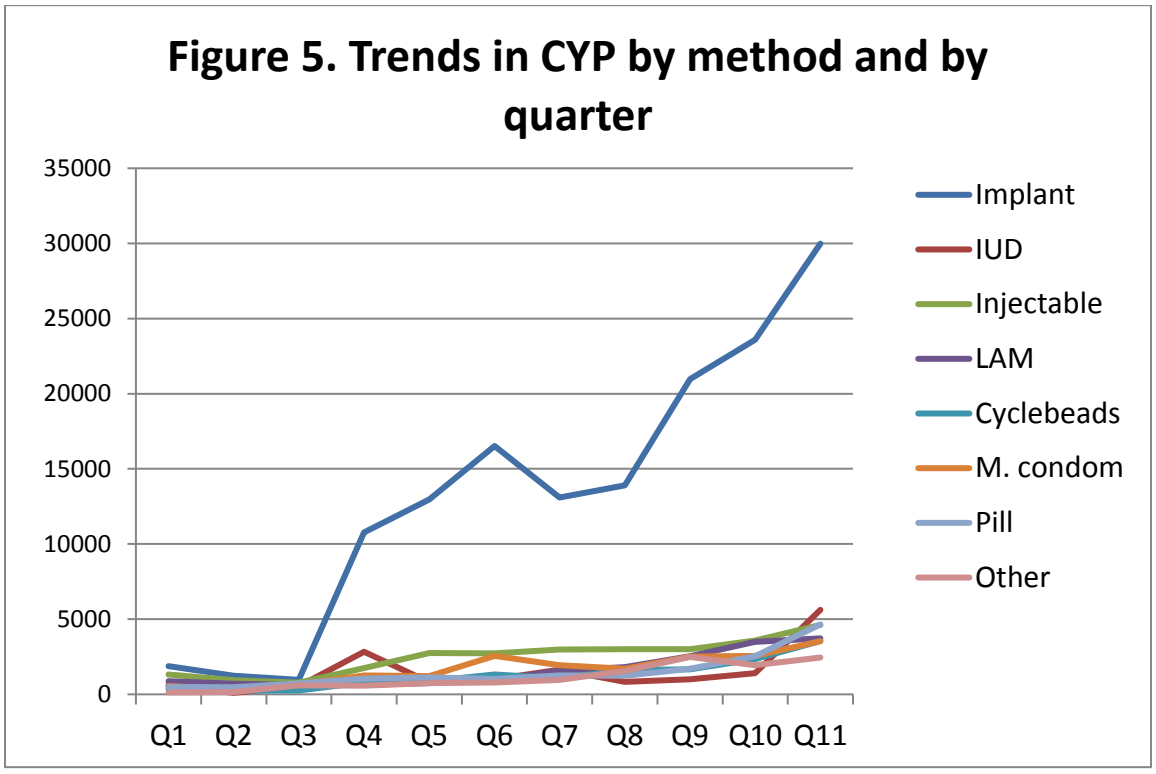


Figure 5 illustrates changes in method mix over the life of the project (11 quarters), based on CYP corresponding to each method. It demonstrates the remarkable uptake of the implant in comparison to other methods.

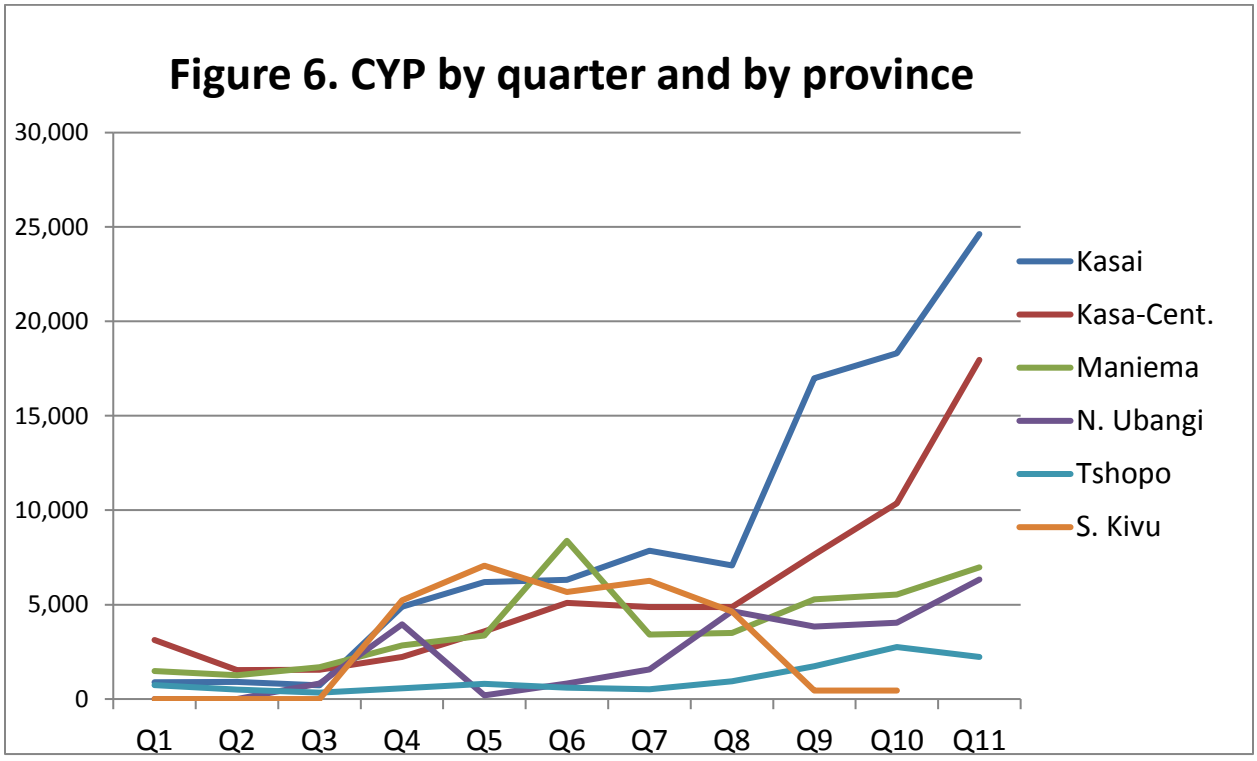
As a caveat in interpreting Figure 4-a, 4-b, and 5, it is important to remember when a client adopts the implant, the CYP "credit" is 2.5 (estimated number of years she will continue with that implant); the program gets all 2.5 in the quarter in which the method is adopted, even though the protection for that method will occur in subsequent quarters/years. (However, the same is true of the IUD, yet it barely rises over other methods on this chart.) Even with this caveat, the predominance of the implant is striking.



As shown in Figure 6, different provinces vary in CYP performance. Because CYP is a "numerator indicator" (which does not take into account of the population of the catchment area), provinces with a larger number of ASSP-supported HZs would be expected to generate a higher CYP, all else being equal. The trends in Figure 6 indicate that Kasai (which has 17 HZs) and Kasai Central (with 11 HZs) were similar to other provinces through the first eight quarters of the project. However as of Q9, they've shown dramatic increases in CYP. Maniema (with 10 HZs) experienced a peak in Q6 but subsequently has generated a lower level of CYP than Kasai and Kasai Central. Tshopo (with only 3 HZs) has generated far fewer CYP. Nord Ubangi (with 11 HZs) was delayed

in receiving training and commodities, but showed a notable uptake in Q4, followed by a dip in Q5 but general upward progress in since then. South Kivu (4 HZ) showed a strong performance between Q4 and Q8, but ASSP support was discontinued from this province thereafter.

The relatively strong performance of the Kasai provinces in Figure 6 is particularly noteworthy when one considers the mCPR at the time of the ASSP baseline survey in 2014. Modern contraceptive prevalence was 2.5% in Kasai/Kasai Central, compared to 12.3% in Maniema/Tshopo (see Section V of this report). Thus the trends in CYP diverge markedly from the expectations based on modern contraceptive prevalence as of 2014.



Note: Sud Kivu was dropped from the ASSP project in mid-2015 and thus there are no data for this province in Q11.

D. Targets and results for number of new acceptors

1. Definition of the indicator: number of new acceptors

According to Pathfinder, the project defines "new acceptor" as a client who has never used modern contraception and uses it for the first time through the ASSP project.

This indicator "number of new acceptors" is often collected in FP programs in developing countries, because it is intuitively appealing. Programs want to measure the extent to which they

are attracting additional clients to the program. Moreover, the concept seems clear without lengthy explanation (in contrast to CYP).

However, "number of new acceptors" is not one of the FP2020 core indicators for several reasons. First, there is considerable variation in its operational definition (i.e., how it is measured), not only in the ASSP project, but in programs worldwide. According to Pathfinder, it is supposed to refer to a woman who has never used contraception and uses it for the first time through the ASSP project. However, at the field level it is often applied to (1) a woman who is new to the health facility but previously used contraception from another source; (2) a woman who used a method previously, decided to become pregnant and have a child, and then returned to contraception; or (3) a woman who switches from one method to another (new) method. In short, even when the definition is clearly stated at the central level, it is often incorrectly applied in counting clients at the field level.

A second reason that number of new acceptors is not part of the core indicators for FP2020 is the lack of correlation between number of new acceptors and mCPR. In a country such as the DRC, a program could have many new acceptors but still maintain a low mCPR, especially in the presence of high discontinuation rates. By contrast, a country such as China with a very high mCPR might have a relatively low level of new acceptors, since most eligible women already use contraception.

However, the indicator "number of new acceptors" does figure in the log frame for the ASSP project and thus is included herein.

2. Methodology for establishing targets for number of new acceptors

IMA/Pathfinder has used historical data to establish the targets for number of new acceptors, which are shown in Figure 7.

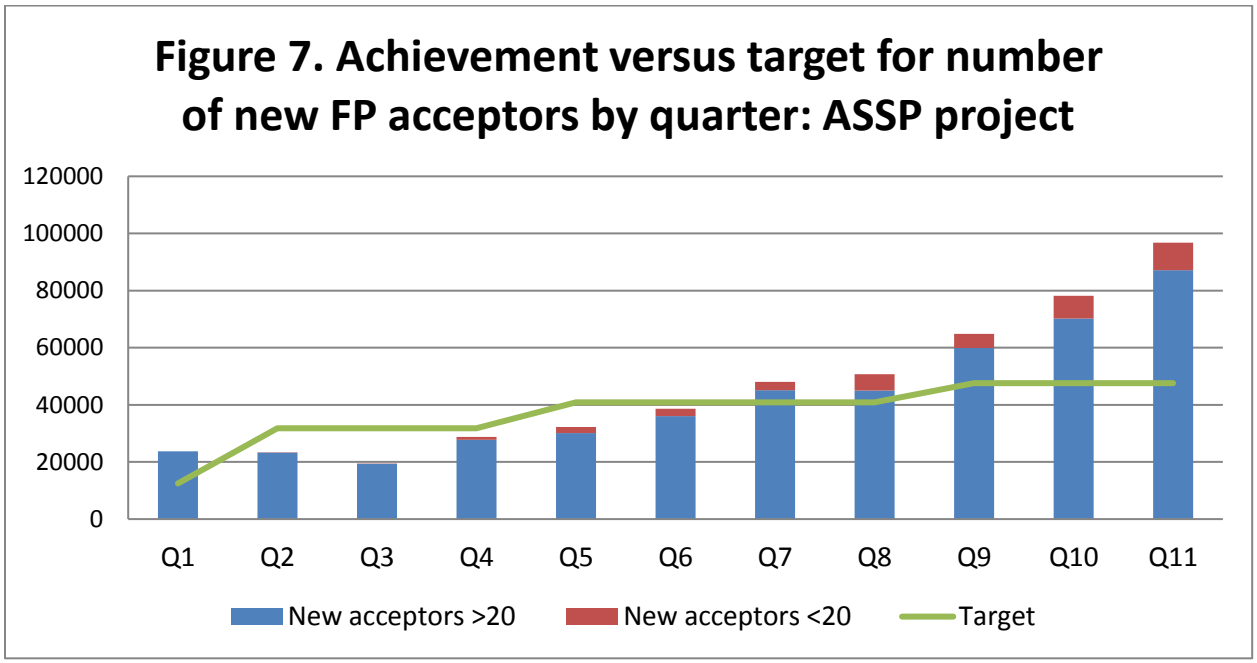
3. ASSP achievement in family planning based on targets for number of new acceptors

Using the same data set as IMA provided to Pathfinder for this purpose, the Tulane team had no problem replicating the data on number of new acceptor shown in Figure 7. (A similar graph is available from the Pathfinder quarterly report dated February 2016; see Figure 1, page 16).

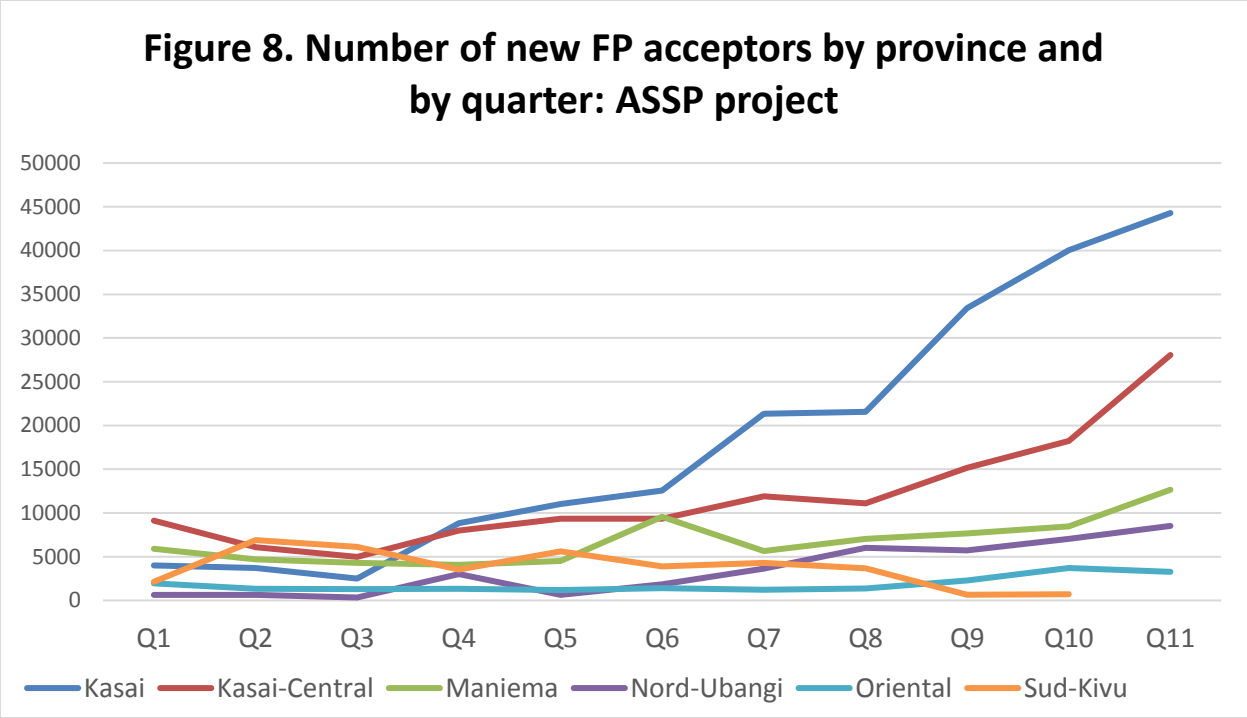
Figure 7 illustrates the steady increase in number of new acceptors over the 11 quarters of the project. It also reveals an interesting trend that for most of the first six quarters, the number of new acceptors was **lower** than the target (shown by the green line). However, starting in Q7 and continuing for the remaining four quarters, the number of new acceptors consistently outpaced the target value. As of the most recent quarter (and as noted in the Pathfinder report), the total number of new acceptors (97,135) was more than double the quarterly target (47,591).

The target for the total number of acceptors over the first 11 quarters of the project was 720,760. The ASSP project achieved 914,157 new acceptors, thus exceeding the target by 27%.

Figure 7 also shows the percent of new acceptors under age 20 as a proportion of all new acceptors. Given interest in reaching younger women with FP, the gradually increasing percentage of women less than age 20 (albeit still only 10% of the total as of quarter 11) is encouraging.



As with CYP, the number of new acceptors is a "numerator indicator." To give some sense of perspective, we include the number of HZs per province in the data shown in Figure 8. This being said, Kasai (17 HZs) and Kasai Central (11 HZs) generated by far the largest number of new acceptors.



Note: Sud Kivu was dropped from the ASSP project in mid-2015 and thus there are no data for this province in Q11.

E. Limitations of this analysis

One limitation of this analysis is that it is based on service statistics provided by the ASSP project. It would have been impractical for Tulane as an external evaluator to establish a parallel data collection system. Tulane has no reason to doubt these numbers, but recognizes this inherent limitation of this analysis.

We add the following caveat to this analysis. The current levels of CYP generated by the ASSP project do not "guarantee" that the projected level of mCPR will be attained by the end of the project. For example, the CYP conversion factor for Implanon is equal to 2.5 (the mean number of years that women are expected to retain the implant, based on research from other developing countries). If large numbers of women in the ASSP catchment area were to discontinue use of the implant within a year of insertion, this would invalidate the calculations that link the level of CYP to rate of mCPR, and the project would not achieve the projected two percentage point increase per annum in mCPR. At present, we have no data to support or rule out this possibility.

In the absence of local data to validate CYP conversion factors (which few if any programs have or use), these numbers represent the most solid evidence available that the ASSP project is on target to achieve its objectives in the area of FP.

F. Conclusions regarding achievement of targets for CYP and number of new acceptors

From the findings in this section, it is evident that the ASSP project has surpassed the target levels for CYP and number of new acceptors over the life of the project. Key findings in support of this conclusion are as follows:

- **CYP**: the ASSP project exceeded its CYP target by 15% in 2014 and by 63% in 2015 (or by 48% for the two years combined).

- **Number of new acceptors**: over the first 11 quarters the ASSP project exceeded its target by 27% (720,760 expected; 914,157 achieved). In the most recent quarter the project generated over twice as many new acceptors as targeted.

As mentioned earlier, DFID specified in its contract with IMA that if the project did not meet its CYP targets by Year 3 of the project, then IMA should reprogram its funding to improve performance in the area of family planning. **The results of this analysis (as well as Pathfinder's internal reporting) indicate that the project is not only achieved, but exceeded its CYP and new acceptor targets.**

The current analysis represents value added over the internal reporting of Pathfinder in three ways: (1) it provides validation of the calculations from an external source; (2) it includes the corrected CYP factors, consistent with the globally accepted conversion factors; and (3) it introduces an empirically-based means of establishing CYP targets that are linked to projected increases in mCPR over the life of the project.

IX. Attitudes toward family planning in the ASSP Project

As mentioned earlier, this case study used both quantitative and qualitative methods of data collection. The final sections of results are based on key informant interviews among MOH personnel at the central and provincial level, MCZ, IPs, and focus groups among members of the community. Whereas earlier sections of the results constitute secondary analysis of existing data sets, the qualitative findings were collected specifically for this case study. The full report of the qualitative findings is available in French (*Analyse de l'offre et de la demande de la Planification Familiale dans les zones de santé appuyées par le projet ASSP en RDC. Étude des cas*, January 2016.)

A. Perceptions of MOH personnel from the central level (Kinshasa)

The research team interviewed personnel from the MOG at the central level (Kinshasa) regarding the following points:

- position of the government on FP
- public declarations by high-level government officials on FP
- measures taken by the government that support FP
- reasons for the government to be favorable or unfavorable toward FP
- the types of FP activities implemented at the provincial level
- the role of FP in integrated health service delivery

The key theme from these interviews is the strongly favorable attitude of the DRC government toward FP, as shown by several key actions. The government has created a line item in the budget for the purchase of contraceptives. It has repeatedly issued public statements in favor of FP during the three national family planning conferences held in Kinshasa. At the third International Conference on Family Planning held in Addis Ababa in 2013, a representative of the Prime Minister's office gave a declaration of commitment that FP is a priority in the DRC.

In terms of concrete measures regarding FP policy, a new law has been introduced to Parliament by the MOH to overturn the old law from the colonial period that prohibited the sale or promotion of contraceptives.

There are several reasons that the government favors FP. First is its close link to the reduction of maternal mortality. In addition, it represents a means of addressing the eminent doubling of the population in the next 25 years; the government sees rapid population growth as an obstacle to the development of the country.

In the opinion of these key informants, the position of the central government affects the implementation of FP activities at the provincial level, because the decisions taken at the central level are applied at the provincial and peripheral level. For example, norms and directives about FP that are developed at the central level are then applied in health facilities at the peripheral level

(HZs). In terms of the integration of FP into the broader range of health services, MOH personnel at the central level indicated that "the ideal" would be that each woman who goes to a maternity centre for prenatal care, delivery, and postpartum care should receive counseling on contraceptive methods. FP should be a priority intervention in integrated health services.

B. Perceptions of MOH personnel at the provincial level

Key informant interviews were conducted among the chief of the DPS, the Provincial Medical Inspector, and the PNSR Coordinator in the three selected HZs. Topics covered included implementation of the ASSP project, the role of FP in the ASSP project, the perceived position of the government on FP, the opinions of men and women in their communities about FP, and different strategies for promoting FP.

The key informants indicated that they not only knew about the ASSP project, but had been involved in its implementation (e.g., provider training, monitoring and supervision of activities, renovation of health facilities, quarterly and annual reviews of activities).

Provincial health officials in Kasai and Maniema indicated that family planning held a priority position within the ASSP project.

> *Family planning is a priority; the proof is that before the start of the project, the indicators [for FP] were poor but now they are improving and contraceptives are available in most facilities although there is occasionally a stockout.*

By contrast, their colleagues in Nord Ubangi noted the delays in integrating FP in their province.

> *In comparison with other interventions such as vaccination, HIV, and malaria, I would say that family planning has not been a priority, although the providers have been trained and activities are being implemented.*

Officials at the provincial level perceived that the DRC government is strongly favorable to FP. They cited the following reasons: existence of the PNSR at the provincial level and the provision of FP services in local health facilities, authorization by the government for international and national NGOs to provide FP services, the existence of contraceptives on the list of 13 essential medications, the decree by the Prime Minister that conferred official status to the CTMP (the FP stakeholders group), and participation of high-level political authorities in national and international FP conferences.

The key informants were asked how the men and women in their communities felt about FP. A key theme that emerged was that men constitute a major obstacle to FP for a variety of reasons; they believe that FP favors prostitution of women, modern methods have negative effects on the health of women, FP hinders families from having numerous children, and FP should be left to women. Illustrative comments were:

Men say, "I don't have any money, should I also not have any children?"

Men that are not favorable toward family planning confuse it limiting births.

However, a minority of key informants at the provincial level felt that some men do recognize the benefits of FP for the health of the wives.

Key informants were also asked about the views of women in their communities toward FP. They indicated that women are generally favorable toward FP, but consider that the man has the final say in the matter.

Women are tired of continuously being pregnant; they would like to limit their births.

Women see family planning as an opportunity to rest between births.

Overall women are favorable toward family planning, but they hesitate to use it based on rumors and the fear of side effects they've heard about FP.

When asked about strategies for promoting FP, the key informants at the provincial level recommended the following: to target males because they are more reticent about FP, to supply health facilities with contraceptives and avoid stockouts, to raise awareness of the community about the advantages of FP including for young people, to strengthen the capacity of clinical and nonclinical providers to offer FP services, and to organize in the near future a follow-up to the training already given.

C. Perceptions of the chief medical officers (MCZ) at the health zone level

The MCZ represent the MOH personnel responsible for the delivery of health services in their respective HZs. The key informant interviews covered topics similar to those for the provincial health personnel.

The MCZ not only knew about ASSP, but were the ones who were implementing it.

We signed a memo of understanding with the ASSP project and we count on obtaining results, notably the improvement in indicators for health in general and family planning in particular.

They mentioned that they regularly visit health facilities, participate in the training of providers, organize work meetings with health personnel, and participate in the renovation of health facilities in their zones. They also mentioned benefiting from several ASSP trainings, notably the training in management.

When asked about the place of FP in the ASSP project, all MCZ indicated that it was considered a priority.

The ASSP project focuses on the health of mothers and children; family planning occupies a preferred place in the project because it contributes to the reduction of maternal and child mortality.

In explaining the relative importance of FP within the ASSP project (in comparison to malaria, HIV, vaccination, etc.), several MCZ commented that FP clearly had a priority position given the volume of activities that have been conducted, including training of health care providers, training of community health workers, supplying of facilities with commodities, and related activities.

The MCZ perceived the position of the government to be favorable toward FP for the following reasons: FP activities are integrated into the HZ and supported by the PNSR, the government encourages its partners to support the FP component, and the government permits the use of radio and television at both the national and provincial level to raise awareness about FP.

The MCZ were asked, "In addition to the instructions you have received from superiors in the Ministry of Health hierarchy, have you received other directives from those responsible for the ASSP project in terms of family planning?" The MCZ indicated that they only receive directives from MOH, and they follow those directives. However, in terms of service statistics, in addition to those included in the SNIS package, there are some additional data that the project requires to document key indicators such as nutrition, vaccination, and FP. The additional indicators that they report form part of a contractual agreement between the HZ and ASSP project.

In terms of attitudes toward FP among men in their HZ, the MCZ reported that men generally are not favorable toward it. They believe that FP methods will have negative side effects and will leave their women infertile. In addition, some believe that FP promotes prostitution, that FP is only for Europeans, that FP will hinder the DRC from being sufficiently populated, and that God gives children and thus one must have these children. Specific quotes include:

Men believe that if the woman uses family planning, she won't have any more children.

For men, children are wealth, a source of strength.

For men, the Bible says to go forth and replenish the earth.

In terms of women's attitudes toward FP, the MCZ from four of the six health zones felt that the majority of women are favorable toward FP, although they sometimes are worried about side effects such as bleeding, missed periods, and weight gain. One mentioned that women felt that:

Having a lot of children brings on old age and reduces longevity.

However, other women in their community (particularly in Bili in Equateur and Kampene in Maniema) were against FP; they characterized attitudes of women in their communities by the following:

Having a lot of children is a social value and increases your standing in the community.

The research team asked the MCZ about the availability of contraception in their HZ. With the exception of one HZ (Alunguli) where demand was apparently met, all other MCZ reported inadequate contraceptive supplies and frequent stockouts. This was particularly true for the implant, which is the preferred method by many clients.

> *Contraceptive resupply is irregular; if the products were available, I think there would be an increase in users*.

> *Implants are an innovation, they give long-lasting protection and have less side effects. By contrast, it is necessary to take the pill every day and not forget.*

In response to the question "what do you need to promote family planning in your health zone?" the MCZ replied: regular resupply of contraceptives, awareness raising at the community level to combat rumors, greater implication of men in FP because they constitute the barrier, the training of young people (the new or future parents) in RH, and monitoring and regular supervision of trained health workers and activities at the field level.

In terms of the main challenges for FP, the MCZ mentioned the lack of financial support from the DPS, frequent stockouts of contraceptives, the low level of education of the population that does not allow them to recognize the advantages of FP, the difficulty of organizing educational sessions in the villages because women spend much of their time in the forest, and the lack of female personnel to offer FP services.

> *Women make little use of family planning services because they say that the majority of service providers are men and they are bothered by the idea of having an IUD inserted by a man and that these men would then try to become "friends" with them*.

D. Perceptions of the IPs

Pathfinder International is the lead partner for the FP component of ASSP. Three partner organizations are responsible for implementing the ASSP project at the field level: Caritas, SANRU, and World Vision. To better understand how the project works at the field level, the study sought responses from these organizations at the national and provincial level on the following topics: their role in implementation, the place that FP occupies in the larger project, existing levels of collaboration, problematic aspects about the FP program in the provinces they supervise, the difficulties they have encountered, the lessons learned and recommendations for improving implementation.

As lead partner for FP, Pathfinder provides technical assistance in the conception and implementation of the RH/FP program in partnership with the MOH and the IPs. It organizes training of trainers at the national and provincial levels and works with FP actors at the field level (health care providers and community workers). Pathfinder updates manuals' contents, designs supervision tools, and develops plans for improving activities at the field level. In addition, it

determines the types and quantities of products/commodities that the project will need and orders these products.

The partners at national and provincial level see their role as coordinating activities for the implementation of the project. Those at the national level provide general orientation to the provincial level regarding technical support to the HZs (trainings, review of the work); resupply in medications, products and materials; financial management; monitoring and supervision of activities led by IMA including construction/renovation of health facilities.

The partners at the provincial level work directly with the HZs to assure the implementation of the project which consists of delivering to the HZ the support envisioned in the framework of the project (financial, material, logistical), providing technical support which consists of working with government partners in reinforcing the capacity of service providers and in raising awareness about FP at the community level.

The place of family planning in the project. Key informants at both the national and provincial level replied that FP has a preferential place in the ASSP project. The project focuses on improvement in the health of mothers, newborns, children, and adolescents; FP is one of the strategies to attain this objective. Pathfinder pointed out that FP indicators are among those that will be used to evaluate the performance of the project.

One exception was Nord Ubangi, where the integration of FP into the HZs was delayed; as a result, FP does not yet occupy a preferred place within the project.

> *If one compares family planning with other intervention such as HIV, vaccination, malaria, etc., FP is not a priority intervention, given that it was only recently integrated into our health zones whereas the other activities had begun long before.*

Collaboration between Pathfinder and the Implementing Partners. Overall, both Pathfinder and the IPs (Caritas, SANRU, and World Vision) felt the collaboration was working well. However, the IPs remarked on the following weaknesses: delays in the delivery of products, the rather long period of time between the training and supervision post-training, and the frequent stockouts of contraceptive methods.

Pathfinder gave examples of the strength of the partnership: during the training of MOH personnel (nurses, doctors), at least one staff member from the partners participated. One of the weaknesses of the project is the additional burden of work, because the MOH personnel that should be implementing it often have other tasks, which slows down the rhythm of work on ASSP. In addition, in the health facilities throughout the country much of the personnel do not receive salary payments on a regular basis, despite responsibility of the government to pay them. Thus, these personnel cannot offer quality health services, and this leads to weak buy-in to the project. According to Pathfinder, there are various reasons for the stockouts: lack of product, the poor management of products (products that are at the warehouse but not requisitioned in time), and the

poor management of products at the HZ level. Sometimes there is an oversupply of contraceptive products in some health facilities whereas others are stocked out.

Problems encountered in implementing the family planning component. Pathfinder commented on several problems encountered in implementing the project, the first of which was stockouts of contraceptives. Second, service providers are expected to offer FP despite the fact it goes against their own religious convictions. Given that modern methods are unacceptable to [the Catholic] religion and some service providers are deeply religious, it is difficult if not impossible for them encourage women to use FP. Third, there is the lack of information about the advantages and benefits of FP, and rumors are very widespread at the community level. Fourth, service providers sometimes remain inactive after training due to a lack of supervision by the MCZ and DPS. Finally, poor management of contraceptives at the HZ level including "leakage of products") frequently explains the stockouts.

Key informants from the three IPs cited several problems: the preference for single method (implant) that is often not available; the low use of injections and pills; rumors regarding FP methods; the refusal to use permanent contraception; the frequent stockouts of contraceptives due to the poor management of products (contraceptives are not ordered in time). Other problems mentioned were the strongly pronatalist culture ("children are our wealth"), the lack of male participation in FP, rumors about contraceptive methods, and insufficient personnel that offer FP services. For example in the absence of the *Infirmier Titulaire* (head nurse, or IT), FP services are not offered.

The IPs also noted that religion constitutes a problem that they have encountered in implementing FP in the provinces. The population thinks that FP limits births and using FP goes against God's wishes, because it is God who gives children. Another community attitude that restricts the uptake of family planning is the belief that women using FP will be unfaithful; FP favors prostitution because men can no longer control their women.

Although it does not relate directly to FP (which is given free of charge), the IPs noted that the population has difficulty in participating in a paid system of healthcare, given that the project that preceded ASSP and was implemented by Merlin in Maniema and IRC in Kasai was based on free healthcare. Also, they noted a drop in motivation among providers who no longer receive a bonus payment (*prime*), whereas workers did under the previous project; and often there is a single person who provides family planning in a health facility, which is the IT. Other difficulties included contraceptive stockouts, poor utilization of products by the providers (including leakage of products), the lack of IEC materials for educational sessions, and rumors about contraceptive methods.

Recommendations for improving the provision of FP services in the future. Pathfinder recommended developing an initiative on male involvement, working with the MOH on the

organization of activities, and implicating community leaders in the program. Recommendations from the IPs included:

- ensuring contraceptive availability
- intensifying awareness raising activities among the community
- increasing the number of FP providers in health facilities
- organizing follow-up to training soon after the training
- implicating the DPS as in the development of the timetable for FP activities
- improving communication between the relevant partners: the DPS, IMA, the Implementing Partners, and the health zone
- exchanging experiences among the partners regarding strengths and weaknesses of implementation, and
- implicating men in FP.

X. Attitudes of community members toward family planning

Whereas access to contraception is a key factor in contraceptive uptake, so is demand for modern contraception. This case study included a total of 36 focus groups among men and women living in communities supported by ASSP to learn more about community attitudes, opinions and perceptions regarding FP. The 36 focus groups were evenly divided across Kasai, Maniema, and Nord Ubangi. In the description that follows, we report the findings from the following focus group participants:

- married women 20 to 30 years old with children
- married men 25 to 34 years old with children
- unmarried women 18 to 24 years old with no children
- unmarried men 18 to 24 years old with no children

The results of this research are presented in detail in a report in French entitled *Analyse de l'offre et de la demande de la Planification Familiale dans les zones de santé appuyées par le projet ASSP en RDC (Étude des cas)*. Moreover, it presents the findings separately for each of the groups noted above. The current report summarizes key themes from the larger report around the key topics addressed in the different groups.

A. Attitudes among married men and women toward family planning and related topics

Key topics for the focus groups among married men and women included community norms around family size, husband-wife communication over the number of children desired, husband-wife differences in desired family size, persons outside the couple who try to influence family size, knowledge of modern contraceptives and places where FP services are available, access to modern contraception, reasons for use or nonuse, and intentions to use in the future.

1. Community norms around family size

According to both women and men, community norms favor having a large family (at least 5-6 children, if not more) for several reasons: children are riches; parents have many children in hopes that at least one will be able to go to school and help the parents in the future; and children are a gift from God.

> *In our culture as Africans, children are "riches" for us. One must produce many children because you do not know which one will help you. By contrast, if you have two children and they die, there will be no one to care for you* (husband of a user, Mutoto)

> *In general, we have many children because the Bible says,"multiply and replenish the earth," and even if you have nothing to feed them, God alone knows how they will grow up" (husband of a user, Mutoto)*

People want to have more children so that there is at least one child who has the means to help parents because not all the children will be schooled for lack of funds. (Wife/user, Mweka)

2. Spousal communication regarding the number of children desired

Both male and female participants agreed that husband-wife communication on the number of children the couple would have is relatively uncommon in their communities. Participants across groups explained that the man often imposes his decision on the wife because he is the head of the family. Others indicated the futility of such discussion since God alone decides how many children a couple will have. Even if a couple has an initial agreement, they may need to change it later on, for example if the woman experiences health problems. Others cited the case of having an agreement but ending up with a large number of children because they did not use FP.

No, we never talked about the number of children with my wife at home because we know that it is God that gives children and he is [determining] the number of children (husband of a non-user, Bili)

No, we don't need to discuss the number of children; it is the man who makes the decision, he is the head of the family and it is he who pays the dowry " (husband of a non-user, Bosobolo)

Here in Kampene, the man and woman don't come to an agreement, because the man wants to have children until the woman can no longer give birth, couples want to have many children. (Husband of a user, Kampene)

At first, we did not discuss the number of children with my husband but now I have health problems and I give birth each time by caesarean section, so we decided to limit the number of children, which is why I use the FP (wife/user, Kampene)

Initially we had agreed with my husband on the number of children to have, but we did not use PF; now we have a large number of children, which is not what we had wanted (wife/user, Bili)

No, there's no agreement between husband and wife on the number of children, because often the man alone decides how many to have (wife/user in Bili).

It is the man who decides on the number of children. The man wants the woman to have many children so she can grow old quickly so that no man might still love her after he dies.

But if she has only 2 or 3 children, another man might still marry her (wife/non-user, Mweka)

Among the Ngbaka, it is the man who decides the number of children. People here think that if they have many children, living conditions will improve because the children will help their parents and they live with this hope. A woman is also happy to have many children because she thinks with this many children, her husband cannot divorce her '(wife/non-user, Bosobolo)

A minority of men expressed their views as follows:

We agreed with my wife to have only two children. We set this number because we do not have the means, we think that [having children] beyond that number will bring poverty, misfortune ' (Husband of a user, Alunguli)

Women not using contraception gave mixed replies:

'We haven't really discussed it. We just want to keep having children until menopause. My parents put me in the world, I also have to put [children] in the world (wife/non-user, Alunguli)

My husband told me that we will have that 5 children and I agreed because we have a lot of difficulties at home and besides, we only have the products of our fields to live on (wife/non-user, Bili)

Even women using modern contraception gave mixed replies about husband-wife communication:

No, for us there's no agreement on the number of children. It's God that's going to give us the number of children that we should have (wife/user, Alunguli)

3. Husband-wife differences in desired family size

Both men and women agreed that it is the man who wants more children than the woman, especially if the man considers that he is from a small family. In a patriarchal system where children belong to the man, he tends to want to have many offspring. Moreover, as head of the household, the man thinks he has the right to decide all matters related to reproduction.

*For me, it is the man who seeks to have a lot of children especially if he was born of a small family. He will look to the woman to give birth to many children (*wife/user, Mutoto)

It is the man who wants to have more children so that these children can help when he is no longer able to cultivate the fields and do other farm work (wife/user, Mweka*)*

If women only were to decide, they would want to plan their births because they know that every pregnancy carries a risk of mortality and morbidity.

Men want to have more children because they are not experiencing labor pains; but we women feel that pain during childbirth and we want to limit the number of children (wife/user, Alunguli)

The husband's support of family planning emerges as the determining factor, even if other family members are opposed:

My husband and I agreed to use a contraceptive method. When my sister-in-law learned that I was using these methods, she turned against me and we quarreled. But since my husband was favorable toward FP, I use contraception without any problem (wife/user, Bosobolo)

Whenever I talked to my husband about family planning, he was happy. He told me to keep taking the method to avoid getting pregnant for at least three years (wife/user, Mweka)

4. Persons outside the couple who try to influence family size

In terms of other people outside the family who try influence the decision regarding number of children, participants identified their parents, aunts, uncles, sisters, brothers, and family friends. Generally these people intercede when they see the couple does not have a lot of children. The reasons include grandparents wanting to have grandchildren, the belief that children are "riches," and the fact that the family has paid its dowry and deserves children in return.

There are friends who also influence [this decision] because we Africans, if you did not many children, you are considered poor in the community (Husband/non-user, Bosobolo)

It is the man's parents influencing their child to have many children. They say it is not for nothing that we gave you money to pay the dowry " (Husband/non-user, Mutoto)

My mother-in-law told me one day that she had wanted to have a lot of children but was unable to. {She said] 'the children I wanted to have – it's now up to you to have them' (wife/user, Mweka)

It is the family members of the man who influence a couple to have children in order to enlarge the family. If their brother does not have many children with this woman, they will encourage him to take another woman (wife/user, Mweka)

The grandmother influences the number of children in the household. She comes to tell her son that he must have many children because among them there will be doctors, nurses, judges etc. (wife/non-user, Mweka)

5. Community attitudes toward family planning

Answers to this question were mixed. Many cited cultural norms and religious reasons that communities were against family-planning. Others mentioned that at least some members of the community were becoming more open to family planning. Even women who use modern contraception felt their communities were unfavorable toward the practice.

People say that these methods can make the woman barren and it is very bad to use them (wife/user, Mweka)

Men say that these methods will cause diseases, others say that these methods we will burn our organs. For now we put all these comments into the hands of God, who is our only refuge (wife/user, Kampene)

Some members of our community say it's not good to use family planning methods because they make the woman sterile (husband/non-user, Mutoto)

Churches are against these methods that don't conform to the word of God which says to "multiply and replenish the earth" (husband/non-user. Kampene).

Similar reasons were given across the different focus groups: it favors prostitution, family-planning is for Westerners, family planning hinders families from having a lot of children, and contraceptive methods cause sterility or bleeding. People identified as being most against family-planning were pastors/priests, grandparents, and older people.

Whereas communities were viewed as being against family-planning, a number of individual participants spoke up in its favor, suggesting that the community norm does not apply to all.

6. Knowledge of modern contraceptives and where to obtain them

In terms of knowledge of modern contraception, the situation differed greatly depending on whether the woman used a method. Among women not using modern contraception, the majority had heard about modern methods; they could name a few (the pill, Depo, the implant); and knew that they are available in health facilities.

Husbands of nonusers were less likely to know about modern contraception, although a few could mention condoms, Depo-Provera, and the implant. Others had heard about recent educational campaigns to explain modern contraceptives.

7. Reasons for use of modern contraception

Among women who had overcome community disapproval to become users of modern contraception, their reasons for using were as follows:

> *What prompted me to use FP was that my four children were sick. They had anemia and were dehydrated. So I told my husband about family planning. We went to see the nurse at the health centre who advised us to use FP to space births, as there was a risk of losing them* (wife/user, Bosobolo)

> *I had problems with my husband because I refused to have sex with him. The problem was that my baby was still small and I was afraid of another pregnancy. He accompanied me to the health centre and the nurse gave us a method* ' (wife/user, Mutoto)

> *I already have 6 children. We must feed them, send them to school, and cover all their needs. My husband and I decided to stop having children* (wife/user, Kampene)

Among men whose wives were using modern contraceptives, their reasons included difficulty of living conditions (difficulty of feeding their children), health of the mother and child, benefits of child spacing, and benefits of child limiting. They tended to know about contraceptives and felt they were easily accessible at the local health centre. They reported favorable encounters with the health providers at the centres.

> *My wife was well received by the nurses. They explained to her the advantages and disadvantages of the methods. The nurse told her if she had any side effects, she could come back to the health centre* (husband of a user, Bosololo).

Among women using modern contraception, their experiences with the local health centres had generally been favorable.

When I got to the health centre, I found a nurse. I told her I wanted to have a modern method, she then explained the advantages and disadvantages. She said that these methods were free (wife/user, Kampene)

A provider who received me at the health centre was very happy. It was the same nurse who had given a group talk in the community. When she saw me, she had me sit down and I got the method I wanted " (wife/user, Mweka)

8. Reasons for nonuse of modern contraception

Multiple reasons were given for nonuse of modern contraceptives. Men whose wives were not using contraception mentioned the lack of knowledge and information, fear of side effects of the methods, religious considerations, and wanting to have more children.

People are afraid to use these methods because some women who have used them talk about the side effects. There was a woman who said to her friends "I used those methods and I got cancer and I had to go to Goma to get treated" (husband/non-user, Alunguli).

Our culture is not favorable to family planning. People here think that family planning encourages prostitution (husband/non-user, Kampene).

Among men whose wives were not using contraception, participants gave the following reasons:

Me, I do not practice family planning because I still want to do have more children. It is only when I reach 5 to 6 children that I will use the PF (husband of a nonuser, Bosobolo)

I do not know about these methods, I do not see how I will use them" (husband of a nonuser)

I have my doubts because these methods cause disease (husband of a nonuser, Alunguli)

God is against these products. Take for example the condom, the Scriptures forbid man to throw away his seed, whereas the condom collects the seed (husband of a nonuser, Bosobolo)

Women gave similar reasons:

Women who have used FP methods in the past make these types of comments: "I used family planning but I stopped. I wanted to have a child and I could not get pregnant." When our friends hear that, they do not go to the health centre to use these methods (wife/user, Mutoto)

Others refuse because these methods disrupt the monthly cycle. For example, I've used the implant and I had constant spotting. When I told that to other women, they were reluctant to go to the health centre (Wife/user, Bili)

There are men who only pay by a pagne (cloth for making a dress) when they go to the maternity unit. This is why some women give birth frequently. (wife/non-user, Mweka)

If you do not produce many children, your husband's family can come and chase you out of his home (wife/non-user, Bili)

9. Intentions to use FP in the future

In terms of intention to use a family planning method in the future, many of the women who were non-users were open to the idea:

I would like to use these FP methods provided to give me tablets (products) which can stop bleeding (wife/non-user, Bosobolo)

We want to use these methods, but I want to first have information on the disadvantages of these methods (wife/non-user, Bili)

We ask the nurses to do outreach to all mothers so that they have the opportunity to know the advantages and disadvantages of these methods and especially tell us where we can find these methods (wife/non-user, Kampene)

We must involve community leaders, churches, political and administrative authorities and commit all to give us information on these methods, then we will use (wife/non-user, Mutoto)

A number of men whose wives were not using FP also indicated their openness to doing so in the future:

Yes, we will use these methods because if we follow our traditional ways, we will have children who will not study and that will not be healthy because of malnutrition (Husband of a non-user, Bili)

I'm going to use FP in the future because in my family, I have a child every year and a half, and that is creating a lot of problems (husband of a nonuser, Bosobolo)

I agree to these methods for birth spacing. If children are too close, they will have health problems and we will not be able to feed them because we do not have the means. (Husband of a nonuser, Mutoto)

My wife and I can use these modern methods in the future, provided I give my consent ' (Husband of a nonuser, Kampene)

10. Summary of the focus group findings among married women and men in ASSP-supported health zones

The focus groups among married women and men reflected the strong cultural norms toward large families, with men wanting more children than women for multiple reasons. Not all children will survive to adulthood; those that survive will be able to help their parents in the fields and in old age; perhaps one of many will be successful; children are considered a family's riches; children are a gift of God; and having many children is part of African culture.

Husband-and-wife communication about family size is not common in these communities. This is mainly due to the dominance of the man as head of the household. However, if the man is favorable to family planning, the wife feels supported, even against criticisms of other family members or the community. In a minority of cases, the husband and wife had decided on the number of children, either because of the woman's health or the desire to feed, educate and clothe the children adequately.

There are strong familial pressures toward having a large family, especially if a couple has only a few children or if the husband comes from a small family. Having a large family is seen to solidify the household; it protects the woman from being chased away by her in-laws for failure to procreate.

Women using modern contraceptives obviously know about the methods and where to obtain them. Among couples not using contraception, men are less familiar with modern contraception or where to get it. By contrast, women who were not using contraception tended to know about methods and where they could get them. A number of participants implied that they might use modern contraception if they were better informed.

Among couples using modern contraception, the primary reasons were the desire to protect the woman's health, the hard economic times, and the desire to give a better life to their existing children. The reasons for nonuse were similar for men and women, users and nonusers: reported side effects including sterility and other rumors, religious reasons, the pronatalist culture, and a lack of information about the methods.

Among women not using modern contraception, there was a definite openness to learning more about this option. However, these women would want reassurance about the side effects and products to deal with side effects. Some husbands also indicated interest in using family planning in the future, though often after they had had five or more children. They wished to learn more about where these methods are available for use. There was a call for greater involvement of community leaders, churches and political and administrative authorities in family-planning.

B. Attitudes among unmarried young people 18-24 years old

Not only are young people a numerically large portion of the target population in the DRC; they also represent the future of the country. By the age of 18-24, many are already married and have begun childbearing. Others anticipate marriage and the chance to have their own children. ASSP aims to increase knowledge and access to contraception among young people at this formative time in their reproductive life cycle.

To this end the study included focus groups with unmarried young people (both female and male, in separate groups) aged 18 to 24 years old who did not yet have children. The discussion guides were designed to better understand community norms and peer pressure around issues of marriage, sexual activity and contraceptive use. In particular, the study sought to understand barriers to contraceptive use among this age group.

1. Desire to marry and start a family

Among these young unmarried participants, aged 18 to 24 years old, many desired to marry and to start a family. The majority of female participants said that they wanted to be married between 18 and 20 years old, while the majority of male participants said that they wanted to be married between 20 and 24 years old. When asked to explain why they would like to be married at those ages, the majority of female participants noted childbirth factors, whereas the majority of male participants stated educational or economic reasons:

> *I must marry when I am about 20 years old because it is the age of maturity, and I can give birth without problems (Female, Alungi).*
>
> *I want to get married at 19 because I want to give birth early. (Female, Bosobolo)*
>
> *I prefer to get married at 20 years old because first, I need to go to school and find a job before I get married in order to feed my family; I have to have money. (Male, Bosobolo)*
>
> *However, there are young people who marry early at 19 years old when they do not have the capability to continue studies. (Male, Kampene).*

Participants were also asked about their preferred family size. The majority of female participants said that they want 6 children, whereas the majority of male participants want between 6 to 8 children. Both male and female participants stated economic reasons behind this decision:

> *I also want to have many children because among them, there will be one that can become a mason and build a house for us parents, another can plow/cultivate a field, another can even go study and go abroad where he can properly support his family and our future will be assured. (Female, Mutoto)*

> *We must give birth to more children, 8 or 9, because not all of them will live, there will also be those who die. (Male, Bosobolo)*

> *Me, I will have many children because among them there will be a child who has lots of money and that will help me in my old age. (Male, Alunguli)*

A minority of participants in both the female and male groups sought to have fewer children in the future, due to the costs of raising a large family and the desire to provide children with good care:

> *I will only have three children because I will be capable of providing for them, raising them because if you have many children, you need a lot of money too. (Female, Bili).*

> *I will not have many children because life is expensive, it is necessary that we do not follow our parents, me I would like to take good care of my children. (Male, Mweka)*

2. Community or peer pressure regarding sexual activity

Many of these young unmarried people expressed the pressures they felt to have sex, whereas others (though fewer in number) felt pressure to abstain. For participants, the issue was shrouded in shame, embarrassment, and fear of disapproval. A number of participants – both male and female – expressed the pressure they felt from their peers to participate in sex:

> *In our community, the boys are not waiting for marriage before having sex. When they see that their friends do it, they also begin to imitate that. (Male, Mweka)*

> *Some girls have sex because they imitate their colleagues who do it. When they see their girl friends wear clothes that they bought with the money they got from boys, they will mimic them. (Female, Bili)*

Similarly, many participants discussed how not participating in sex would result in them being mocked or embarrassed:

> *We live together, if you do not have sex like the others, we will laugh at you and say that in marriage you will not be a good wife, that's why I encourage sex before marriage. (Female, Mweka)*

The boys sometimes have sex before marriage because we are told that if we do not have sex before we are 18, we will be impotent and people will mock them on their wedding day. (Male, Mutoto)

By contrast, other participants noted the reverse – the pressure from their peers to not participate in sexual activity:

If your friends learn that you have sex with boys, they will consider you a prostitute and you will feel shame. (Female, Bosobolo).

My friends tell me not to have sex before marriage because there are many diseases in the world. (Male, Bili)

3. Parents' disapproval of sexual activity

Most participants felt that parents disapproved of sexual activity before marriage, even if it was a reality in their communities. These young participants – both male and female – explained that parents do not want their children to have sex prior to marriage. Some commonly cited reasons for this involve economic factors:

Adults are not happy [if their children have sex] because parents have suffered a lot to raise their children. They expect to be helped by their children in their old age. With sex before marriage, young people are at risk of contracting diseases and compromising their future. (Male, Bosobolo)

Parents do not want their children to have sex before marriage, especially if their child is a girl. The custom here is that if the girl is a virgin when she gets married, the girl's parents are given a gift, a goat. It is an honor for the parents and for the church where the girl prays. (Male, Mutoto)

Several participants remarked that it is seen as poor parenting if a child has sex prior to marriage:

It is because of the non-monitoring of children by their parents and the bad company of girls that they [girls] have sex before marriage (Female, Mutoto)

For some irresponsible parents, when their daughter is friends with a boy who has money, they say nothing and they sometimes encourage them. (Male, Mweka).

4. Gender differences in perceptions of sex

Both male and female participants described the curiosity of the other sex as a motivation to participate in sexual activity:

Me, I'm doing it [having sex] because I'm curious to know about the body of the girl and also to know if I am sexually active. (Male, Alunguli)

The girls have sex because they seek to practice before marriage, they do so out of curiosity and so that they are loved by the boy. (Female, Mutoto)

Yet there was a clear distinction between the male and female viewpoints of sex. For the males participating in the focus groups, having sex was interpreted as a test of virility and strength, and something that requires practice. If the male's sexual performance were satisfactory, this would win him respect from young women:

A boy should have sex to test his manhood. He should keep his body active to be healthy. And you are respected by girls when you have sex. (Male)

I have sex before marriage because I've learned that if you're not experienced, one day a woman can run away from you because of sexual dissatisfaction. She will look for another man to satisfy her, this is why I have to practice because I do not want to divorce one day." (Male, Kampene)

However, for females, having sex was a testament to their appearance. As one participant described, having sex before marriage is a sign of beauty:

For me having sex with boys before marriage is a proof that one is beautiful because the men come to you. (Female, Kampene)

These results indicate that although these young people are both curious about the opposite sex, young males are more concerned with their ability to perform, whereas young females are more concerned with being attractive to the opposite sex.

Given that a large number of young people do engage in sexual activity before marriage, they run the risk of unintended pregnancy without recourse to contraception. A few of the participants recognized the benefits of contraceptive use, yet they identified several key barriers to greater uptake of contraceptive methods.

5. Lack of knowledge and misinformation

Lack of knowledge and misinformation about modern contraception emerged as key barriers to contraceptive use. Comments from the focus groups reflected a lack of knowledge or misconceptions about modern contraception, as well as misinformation that certain medications prevent pregnancy.

When asked what contraceptive methods were the best for use by young people, different male participants cited three methods: the condom, the calendar method, and withdrawal. The majority of male participants believed that it is the female's responsibility to prevent pregnancy:

> *It's the girl who is responsible for she must know her monthly cycle and it is she who must say that she should not have sex with a man because she is in a fertile period. (Male, Mweka)*

The majority of female participants knew at least one contraceptive method. Methods cited were the condom, the calendar method, Depo-Provera, the implant, abstinence, withdrawal, and the pill. However, a few female participants noted a concern that there was potential for contraceptives to cause sterility. One female participant explained:

> *I was left one day at the hospital to take an injection (Depo-Provera), the doctor asked me whether I had given birth in my life; I told him no, he forbade me to take it; he told me that it is forbidden for girls who have not yet given birth to take it because it makes sterile; he told me to calculate my dates by using the calendar method (Female, Bosobolo)*

Some female participants incorrectly named pharmaceutical products they believed to be contraceptives (but are not) as methods to prevent pregnancy, including Decaris, tetracycline, ampicillin, tanzol, and paracetamol. One female participant stated:

> *Me, when I need to avoid pregnancy, I go to my sister's house in the neighborhood who tells me this: just take 2 or 3 paracetamol tablets before intercourse and you will not get pregnant. (Female, Bosobolo)*

6. Attitudes of clinical staff toward young people who seek contraception

A number of participants – especially young women – indicated that the attitude of health care professionals towards those seeking contraceptive methods was a deterrent to their use of contraceptives. Male participants tended to comment that providers treated them respectfully:

> *When we need information, we will go in the health facilities to speak with the health staff. At school, we must consult the teachers. They are experts, they tell us how to protect ourselves against diseases. (Male, Kampene)*

> *The providers receive us well at the health centre, they like people who come asking for advice on preventing pregnancy. (Male, Mweka)*

However, not all male participants had felt welcomed by service providers:

> *One day I went to the health centre to ask for information about sex, there is a nurse who scolded me. And so, I will not be returning over there for fear of being scolded again. (Male, Alunguli)*

The majority of female participants felt that providers generally had a negative attitude towards them when they sought advice on contraceptive methods. As one participant noted, providers sometimes claimed that the use of contraceptive methods was pushing young girls into prostitution:

> *The nurses do not receive us well because when we ask questions, they see us as bad girls who seek prostitution, thus I cannot ask the nurses or the doctors. (Female, Mweka).*

7. Summary of the focus group findings among unmarried young people in ASSP-supported health zones

The findings from the focus groups among young unmarried women and men, 18 to 24 years old, revealed the strong desire among both sexes to marry and begin childbearing – for women by age 20 and for men a few years later. Community norms dictated that young people should abstain from sex before marriage and some participants appeared to agree with these norms. However, many of the male and female participants indicated the natural curiosity among their age group to have sex, as well as peer pressure to do so. Young men felt they needed to be prepared for sexual activity within marriage; others wanted to reassure themselves of their ability to perform. Young women saw having sex is a sign of being loved or being attractive to males.

The comments from the focus groups implied a fair amount of sexual activity in these communities. Yet there was relatively little discussion of the use of contraception to avoid pregnancy. Two key barriers emerged from the focus groups. First, each young people felt they lacked knowledge of contraceptive methods. The condom was the only modern contraceptive method cited in focus groups among the young men; by contrast, most of the modern contraceptive methods were mentioned by female participants. There is also misinformation that certain products commonly available in pharmacies can prevent pregnancy, when in fact they have no contraceptive effect.

A second barrier was the attitude of health care providers toward young people seeking contraception. Although males found a more welcoming environment, young women had experienced or anticipated disapproval in seeking contraceptives in local health facilities.

It is revealing that the moderators introduced the topic of modern contraception in these focus groups, but participants were not interested or able to talk extensively about this topic. There was some degree of felt need for information and services (as indicated by the participants who recounted their experiences of going to health facility to get contraception). Yet it is clear that much work remains to be done in relation to services for young unmarried adults in this population.

XI. Discussion

The purpose of this case study was to understand how well the FP component of the ASSP project has performed to date; what have been the major accomplishments; what have been the major challenges; and what midcourse corrections might increase modern contraceptive prevalence rate (mCPR) by the end of the project in 2018.

The executive summary provides a synopsis of each chapter in this report (which will not be reiterated here). However, the key take-away points from this report are as follows:

- The ASSP project is one in a series of large-scale integrated health service projects in rural provinces of the DRC (dating back to the 1980s), which has included a FP component. However, ASSP surpasses these projects in two areas: the explicit priority given to the FP component, and the rigorous, comprehensive evaluation plan for the project as a whole, including the FP component.

- The mCPR (the key population-based outcome for evaluating FP programs) was 5.7% among women married or in union at the time the baseline survey in 2014 (with considerable variation across provinces). Although very low by global standards, the mCPR in the ASSP-supported HZs is similar to other rural areas of the DRC. The ASSP project anticipates increasing mCPR by at least one percentage point per year over the life of the project.

- As of 2014 (approximately one year after the start of ASSP activities in some areas) health facilities showed less readiness to deliver FP services than other health services (such as malaria or child immunization). The provinces of Maniema/Tshopo and Kasai/Kasai Central – although still undersupplied with contraceptive commodities – were better equipped than health facilities in Nord Ubangi.

- The report describes the inputs that Pathfinder International has made over the first half of the project in an effort to achieve its FP objectives. The primary activities have been training at different levels, provision of HZs with contraceptives and other supplies, and post-training supervision of service providers. As part of its written agreement with ASSP, HZs must provide service statistics on their activities to IMA in a timely manner.

- The ASSP project is the first in the series of large-scale integrated health service delivery projects in the DRC that will benefit from a formal impact evaluation, consisting of a baseline and endline survey in both intervention and comparison areas. However, these results will not be available until 2018 (at the completion of the project). In the meantime, one can assess progress based on two key output indicators for FP: CYP and number of

new acceptors. In both cases the project has exceeded the target numbers, indicating that it is on course with regard to family planning achievement.

- In-depth interviews with MOG personnel at the central and provincial levels as well as the MCZ in selected HZs provided valuable insight into the functioning of the project. FP is seen as a priority component of the project, consistent with the high-level government commitment to FP in the DRC. In-depth interviews with staff from Pathfinder International and the IPs reflected a collegial working relationship, albeit with some areas for improvement. Collectively, the in-depth interviews at these different levels produced the key recommendations of this report.

- Whereas much of the study focused on the supply environment for FP, focus groups among men, women and young people in communities supported by the ASSP project provided invaluable background information on cultural norms about family size and demand for contraception services. The results reflected a strong adherence to high fertility norms and (among some participants) religious beliefs. Yet some members of these communities had begun to feel the strain of a large family and cited the benefits of birth spacing or even limitation. Nonusers did not rule out the possibility of using in the future.

- The data from various sources triangulated to provide a cohesive vision of the current status of the project, results to date, and challenges for the future. The project is obtaining the desired results in terms of contraceptive uptake, albeit in a cultural context that continues to favor large families. The recommendations below outline the actions aimed at improving the supply environment for FP and bolstering demand.

XII. Recommendations

Improve access to and quality of FP services

1) Improve mechanisms for the management of contraceptive logistics to reduce/avoid stockouts of all contraceptive methods, but in particular the implant, given its widespread popularity in the DRC.
2) Review the adequacy of staffing across all HZs (including willingness to deliver contraceptive methods in view of religious beliefs) and the opportunities to increase the percentage of female providers for FP.
3) Launch programmatic activity promptly after providers are trained; ensure that they receive necessary supplies and equipment at the time of training.
4) Train personnel on how to provide youth friendly sexual and RH services.
5) Continue efforts to ensure regular payment of government workers (for all health services, including FP) as a means of improving motivation.

Increase demand for FP services:

1) Increase knowledge of modern contraception and availability of services through multiple communication channels.
2) Develop communication strategies explicitly focusing on men, given their dominant position in family decision-making, including for FP.
3) Encourage community leaders and service providers to promote greater male-female communication regarding number of children and contraceptive use.
4) Develop community level educational/motivational activities that address key barriers to FP use identified through this and other studies, including fear of side effects.
5) Identify adolescents and young people has part of the target population for FP/RH activities in ASSP supported zones; design and implement activities directed specifically to their needs and interests.

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