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'I have no choice': The perceptions of contraceptive use and abortion practices among women in the Democratic Republic of the Congo

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ABSTRACT

'I have no choice': The perceptions of contraceptive use and abortion practices among women in the Democratic Republic of the Congo

By: Jennifer M. Swanson

Background During the two recent wars (1996-1997 and 1998-2003), the Democratic Republic of the Congo (DRC) has had widespread conflict, civil strife, and rampant poverty. Largely in Eastern DRC, rape and sexual violence against women are still used as weapons of war. The 2013-2014 Demographic Health Survey estimated a maternal mortality ratio of 846/100,000 live births during 2006-2013. Strict abortion laws, high fertility rates, low contraceptive prevalence and lack of emergency obstetric care contribute to the elevated number of maternal deaths.

Objective This qualitative research study was conducted in multiple field sites within four provinces throughout the DRC, each with high fertility rates. This study explores the knowledge of contraception among women, community perceptions of desired fertility, barriers to contraceptive access, and the woman's contraceptive decision-making process during negotiations with the husband. This research study also sought to gain insights into abortion practices.

Methods Women of reproductive age (n=32) and reproductive healthcare providers (n=10) were purposively sampled to participate in in-depth interviews, conducted in four languages (French, Lingala, Tshiluba, and Swahili) within Equateur, Kasai-Occidental, Maniema, and North-Kivu Provinces. Participant recruitment was done through health center visits, door-to-door recruitment, and snowball and convenience sampling. After thoroughly reading the data, code development and application were employed to accurately capture the emic perspective.

Results Thematic analysis identified several key themes relating to socio-cultural influences on contraceptive use: 1) Beliefs associated with contraceptive use incorporated community perceptions along with stigmas and myths; 2) Women's lack of autonomy might be due in part to a patriarchal society; 3) Opinions of abortion practices involved counsel given to the women and the various methods used to abort.

Discussion Through examining high fertility norms, barriers to contraceptive use, and gender hierarchies**,** along with the women's lack of independence, this study concludes that Congolese women are not autonomous in decisions about fertility and family planning, and these decisions are inextricably linked to men. This study also suggests that highly unwanted pregnancies and strict abortion laws may drive Congolese women to utilize dangerous methods to induce at-home abortions resulting in abortion-related infection, complications, and fatalities.

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Chapter 1. Introduction

Problem Statement

Across the globe, 830 women die everyday from pregnancy and childbirth-related causes, many of which are preventable (World Health Organization, 2015d). The World Health Organization (WHO) defines maternal mortality as "the death of a woman during pregnancy, childbirth or within 6 weeks after birth" (World Health Organization, 2015c). Maternal deaths are classified into direct and indirect deaths; direct maternal deaths result from obstetric complications during pregnancy, whereas indirect maternal deaths are caused by illnesses or events resulting from pregnancy-related physiological effects (J. R. Wilmoth et al., 2012).

The use of contraception is one solution to high maternal mortality rates, preventing high parity births, unsafe abortions, and facilitating safely spaced pregnancies. Low contraceptive prevalence coupled with high fertility rates and unintended pregnancies linked with unsafe abortion practices are all contributors to maternal mortality. This research project focused on describing: 1) attitudes toward fertility, 2) obstacles to contraceptive access, and 3) opinions of abortion practices; as well as understanding the woman's decision-making process as it pertains to negotiating the use of contraceptives.

Context of Project

Over the past two decades, the Democratic Republic of the Congo (DRC) has been wrought with conflict, civil strife, rampant poverty and pockets of insecurity. In the two recent wars (1996-1997 and 1998-2003), experts estimate four million deaths and over 50,000 incidents of sexual violence, the latter occurring mainly in Eastern DRC (Omba Kalonda, 2008; Zapata, 2011). In 2006, the DRC adopted a law to address sexual violence and although the DRC Penal Code prohibits rape, unfortunately both are still used as weapons of war today (Organization for Economic Co-operation and Development, 2016).

Overall, the DRC is one of the most impoverished countries, ranking 176th of 188 countries on the 2014 Human Development Index (HDI) (United Nations Development Programme, 2014b). The Gender Inequality Index (GII) is one component of the HDI and suggests the degree to which women are disadvantaged by "showing the loss in potential human development due to disparity between female and male achievements in two dimensions, empowerment and economic status" (United Nations Development Programme, 2014a). In 2014 the GII ranked the DRC 149th of the 155 countries with data available on gender inequalities (United Nations Development Programme, 2014c). Pregnancy is a fragile and complex period of any woman's life and the woman should feel empowered to make the decision to conceive a child. Consequently, Congolese women may be in positions of limited autonomy and control due to the cultural structure of the DRC, increasing difficulty in navigating the decision-making process.

Complications during pregnancy and delivery could occur at each stage of pregnancy, resulting in maternal and child mortality or other debilitating consequences. The Birthing Kit Foundation, an organization dedicated to creating a safe and clean environment for delivery, states that "DR Congo is one of the most dangerous countries in which to conceive", with a one in 24 chance of the woman dying throughout the process (Birthing Kit Foundation, 2016). In 2015, the "State of the World's Mothers" report created by Save the Children ranked the DRC 178th out of 179 countries, followed solely by Somalia, on the Mother's Index – using data on education, economic welfare, political involvement and women's and children's health (Save the Children, 2015). Therefore, the combination of armed conflict, poverty, low gender equality, and political instability has exacerbated the grim conditions Congolese women face in pregnancy and childbirth.

Furthermore, unintended and unwanted pregnancies are not a rare occurrence and are a result of sexual violence, rape, and non-use or ineffective contraception. In developing countries, 80 million of the 210 million pregnancies are unplanned, and 42 million of these women will seek an abortion (Izale, Govender, Fina, & Tumbo, 2014). Each year, 47,000 women die as a result of unsafe abortions performed by untrained staff (Guttmacher Institute, 2015). In the DRC and specifically in Goma, North-Kivu Province, illegal abortions are common; practices such as strangling the baby and disposal of the fetus in gutters are not infrequent (Global Voices Africa, 2012). Consequently, unintended pregnancies and firm abortion laws have been forcing Congolese women to seek these gruesome alternative abortion methods, significantly contributing to the maternal mortality ratio.

Purpose of Project

To enhance previous research concerning contraceptive practices in the DRC, this study will identify current perceptions of contraceptive use among women of reproductive age (WRA). This research study will also identify the consequences of unintended pregnancy in a country where abortion practices are severely restricted. The following evidence will provide vital insights into the underlying reasons for low contraceptive use, challenges associated with unintentional pregnancies, and consequences of restricted abortion regulations in hopes of decreasing maternal mortality in the DRC.

Chapter 2. Comprehensive Review of the Literature

Introduction

The maternal mortality ratio represents the risk of maternal death compared to the frequency of childbirth (J. Wilmoth, 2009). The WHO uses a Bayseian approach to estimate the maternal mortality ratio based on databases provided by WHO, United Nations Population Division, United Nations International Children's Emergency Fund, and World Bank Group (World Health Organization, 2011). The Maternal Mortality Estimation Inter-agency Group uses a methodology directly stemming from previous years estimates (2008 – 2013), excluding late maternal mortality, yet including refinements to best utilize existing country-specific data (World Health Organization, 2011).

Figure 1 represents various consequences of low contraceptive use, ultimately resulting in an increase in maternal deaths. Fortunately, in the past 20 years, the maternal mortality ratio in developing countries has decreased by 40%; a contributing factor is the reduction in unintended pregnancies as a result of increased contraceptive use (Cleland, 2012). However, in the developing world, contraceptive use has not expanded as rapidly as that of developed countries, with negative consequences for pregnant women in those countries. In 2015, the maternal mortality ratio in developing countries was 239/100,000 live births compared with 12/100,000 live births in developed countries (World Health Organization, 2015d). Tragically, Sub-Saharan Africa (SSA) accounts for more than two-thirds of these maternal deaths (World Health Organization, 2015c).

According to a systematic review conducted by the WHO, major causes of global maternal mortality are direct obstetric complications, specifically: postpartum hemorrhage, hypertension, sepsis, abortion, and embolism (Say et al., 2014). In 2014, SSA and Southern Asia

accounted for a combined 83.8% of the global distribution of maternal deaths, and further, SSA accounted for the largest proportion of HIV-related maternal deaths (Say et al., 2014).

The Democratic Republic of the Congo (DRC), located in Central Africa, is the second largest country in Africa and the largest country in SSA (see Figure 2) (Central Intelligence Agency, 2016). The DRC, about one-fourth the size of the United States (see Figure 3), had an estimated total population of 80 million people in 2013 (Central Intelligence Agency, 2016).

According to the seven-year period before the 2013-2014 DRC Demographic Health Survey (DHS), the maternal mortality ratio in the DRC was 846/100,000 live births, more than three times the average of developing countries (Ministère du Plan et Suivi de la Mise en oeuvre de la Révolution de la Modernité (MPSMRM) Ministère de la Santé Publique (MSP) and ICF International, 2014; World Health Organization, 2015a). Constant conflict, strict abortion laws, and high fertility rates, along with low contraceptive prevalence, contribute to the high number of maternal deaths. Contraceptive use is also limited largely due to issues of remoteness, affordability, accessibility, and availability due to reproductive service quality, economic factors, transportation, and cultural beliefs (Kandala, Lukumu, Mantempa, Kandala, & Chirwa, 2015). Researchers have explored these factors to determine specifically how each leads to the crisis of maternal mortality in the DRC.

Constant Conflict

Unfortunately, health infrastructure suffers drastically in the midst of conflict. Eastern DRC is wrought with sexual violence in the form of gang rape, sexual slavery, and forced marriages, all of which can result in unintended pregnancies (Nanivazo, 2012). Reproductive health (RH) services, such as contraception, remain widely unavailable during conflict and civil unrest, leaving the consequences of sexual violence toward women largely unaddressed (Center

for Reproductive Rights, 2013). In a place plagued by conflict, this is a major contributing factor for the need to understand these consequences on behalf of Congolese women.

Unsafe Abortion

In the DRC, abortion remains illegal. In 2013, the *no explicit life exception law* stated "to save a woman's life [the law] may be interpreted to permit life-saving abortions on grounds of the general criminal law defense of 'necessity'" (Center for Reproductive Rights, 2013). Therefore, abortions, albeit illegal and restricted, could be conducted if it is necessary to save the woman's life (Center for Reproductive Rights, 2013). However, the enforcement of such an exception to the law remains unstudied. To heighten the restriction in the DRC, the woman and health care provider can both be charged with 5-15 years imprisonment in cases of obtaining or conducting an illegal abortion (Women on Waves, 2016).

Interventions aimed at increasing access to contraception, safe abortion services, and post-abortion care is vital to decreasing maternal deaths, preventing unintended pregnancies and unsafe abortions (World Health Organization, 2015d). The WHO defines unsafe abortion as "a procedure for terminating an unintended pregnancy either by individuals without the necessary skills or in an environment that does not conform to minimum medical standards, or both." (Grimes et al., 2006).

Family planning (FP) is an integral part in reducing unsafe abortions. In the pre-pregnancy phase, FP interventions promote pregnancies at appropriate intervals, thus reducing maternal mortality (Lassi, Mansoor, Salam, Das, & Bhutta, 2014). While there are limited studies on FP in the DRC, the results of a study in Ghana emphasize unsafe abortions as one consequence of poor FP programs (Rominski, Morhe, & Lori, 2015). In addition, young, unmarried women are most vulnerable to abortion-related morbidity and mortality (Rominski et al., 2015).

Although severe complications from unsafe abortions are a leading cause of maternal mortality, strides have been made to properly train and provide expertise to abortion providers. In 2012 and 2013, the International Planned Parenthood Federation, Africa Region, equipped 10 abortion providers in the DRC with the knowledge of safe abortion practices; unfortunately, recent data on the effect of this initiative is unavailable (International Planned Parenthood Federation Africa Region, 2012).

Given that the DRC has been labeled the "rape capital of the world" paralleled by the existence of strict abortion laws and the occurrence of unsafe abortion practices, the need for contraception in preventing unintended pregnancies is clear (Nanivazo, 2012).

High Fertility Rates

Fertility rates in the DRC vary amongst provinces, with an overall average fertility rate of 6.6 children per woman; in urban locations, the fertility rate is 5.4 children per woman versus 7.3 in more rural locations (Ministère du Plan et Suivi de la Mise en oeuvre de la Révolution de la Modernité (MPSMRM) Ministère de la Santé Publique (MSP) and ICF International, 2014). The provinces with the highest and lowest fertility rates are Kasai-Orientale and Kinshasa, the capital city, at 8.2 and 4.2 respectively (Ministère du Plan et Suivi de la Mise en oeuvre de la Révolution de la Modernité (MPSMRM) Ministère de la Santé Publique (MSP) and ICF International, 2014).

The population in the DRC has increased fivefold due to an annual 2.8% population growth, adding 2 million people per year, "depriving the population of the socioeconomic benefits of controlled fertility" (DKT International, 2016; Kandala et al., 2015). The population of the DRC is quite young, 45% are under the age of 15, many of which do not receive essential RH or FP services (Democratic Republic of the Congo Ministry of Health, 2014). This population momentum results in an increased number of women of reproductive age (WRA),

creating the juxtaposition of a high population growth rate, high fertility rates, and a young population.

In many cases throughout the DRC, at-risk pregnancies are ubiquitous. According to the DRC National Strategic Plan for Family Planning (DRC-NSPFP), even among women in union or marriage, 80% of pregnancies are classified as "at risk" meaning the pregnancies are "too early, too close, too numerous, or too late" (Democratic Republic of the Congo Ministry of Health, 2014). In 2013, of the 3 million pregnancies in the DRC, about 1.7 million of those were considered at risk, with just under half considered "high-risk" pregnancies (Democratic Republic of the Congo Ministry of Health, 2014). Thus, one strategy to decreasing maternal mortality is through the reduction of high-risk pregnancies, which can be accomplished by increased use of effective contraceptives.

Low Contraceptive Prevalence

Notably, high fertility rates decrease as use of contraception increases (Kandala et al., 2015). Specifically, increasing contraceptive use has important benefits: allowing for pregnancy spacing and delayed pregnancies, preventing transmission of HIV and sexually transmitted diseases, and decreasing adolescent pregnancies (World Health Organization, 2015b).

In 2013, the modern contraceptive prevalence (MCP) among WRA in the DRC was 6.5%, when compared with Liberia, a country ranking similarly on the HDI, who's MCP was 19% (Democratic Republic of the Congo Ministry of Health, 2014; Liberia Institute of Statistics and Geo-information Services (LISGIS) and Ministry of Health and Social Welfare and National AIDS Control Program and ICF International Inc., 2014). The DRC-NSPFP aims to increase this countrywide prevalence from its current 6.5% to 19% by 2020 (Democratic Republic of the Congo Ministry of Health, 2014). As illustrated in Figure 4, the MCP varies widely throughout

the DRC provinces, with marked differences in urban areas such as Kinshasa versus rural locations such as Kasai-Occidental Province.

However, less than half of the health zones in the country offer any type of RH or FP services, with more limited access in rural locations (Democratic Republic of the Congo Ministry of Health, 2014). In the DHS-measured provinces, only 4% of rural areas compared with 15% of urban areas offer FP services (Democratic Republic of the Congo Ministry of Health, 2014). Therefore, there is a need for increasing RH and FP services throughout the DRC, with substantial improvements required in rural communities.

Congolese women have also established a request for support in transitioning from unplanned pregnancies to planned pregnancies. Twenty four percent of Congolese women have identified either not wanting more children or wanting to space their births, illustrating a community desire for increased contraceptive services (Democratic Republic of the Congo Ministry of Health, 2014).

Specific Project Background

IMA World Health (IMA), an organization with historic foundation in the DRC, collaborates with the Ministry of Health (MoH). IMA became consortium lead on the Access to Primary Health Care project (Accès aux Soins de Sant*é Primaires – ASSP)*, funded by the United Kingdom Department for International Development (DFID) (IMA World Health, 2015). Pathfinder International, identified by IMA, became the lead technical advising organization of the ASSP project, which aspires "to reduce morbidity and mortality in women and children under five within the 56 supported Health Zones" (IMA World Health, 2015). In figure 5, the structure of the relationship between each entity is displayed.

The objectives of the RH and FP subprojects within the health zones are to increase the number of users of modern FP methods by 13%, and to increase the protection by contraceptive methods during a one-year period by 941,000 couple years of protection (CYP) (IMA World Health, 2015). According to the United States Agency for International Development, CYP is the "estimated protection provided by contraceptive methods during a one-year period, based upon the volume of all contraceptives sold or distributed free of charge to clients during that period" (USAID, 2014).

To achieve these goals and objectives, ASSP liaises with the MoH and focuses on using a health systems strengthening approach – supporting health zones, health facilities, and community-level service delivery (IMA World Health, 2015). IMA and Pathfinder International identified four main provinces in need of further research on RH and FP services with a focus on uncovering the community perceptions of contraceptive use and abortion practices in this setting.

This research project focused on characterizing: 1) current contraceptive usage, 2) general attitudes toward fertility, 3) barriers to contraceptive access, 4) opinions of abortion practices; and understanding the woman's decision-making process and community perception of contraceptive use in the provinces of Equateur, Kasai-Occidental, Maniema and North Kivu. The specific objectives of this research study were:

1) To identify knowledge of contraception among WRA.
2) To identify community perceptions of fertility with a focus on attitudes and the decision-making process.
3) To identify the barriers and facilitators to contraceptive use among WRA.
4) To gain insights into abortion practices with a focus on the methods utilized.

CHAPTER 3. MANUSCRIPT

3.1 Contribution of the Student

My contribution to this research project began after an initial invitation from IMA World Health to conduct qualitative research on the perception of family planning and reproductive health to determine interventions to increase usage in this setting. I then took on the role of primary investigator and formulated the research questions, as well as conceptualized, designed, and implemented the research project within multiple field sites in four provinces throughout the Democratic Republic of the Congo.

3.2 Abstract

Background During the two recent wars (1996-1997 and 1998-2003), the Democratic Republic of the Congo (DRC) has had widespread conflict, civil strife, and rampant poverty. Largely in Eastern DRC, rape and sexual violence against women are still used as weapons of war. The 2013-2014 Demographic Health Survey estimated a maternal mortality ratio of 846/100,000 live births during 2006-2013. Strict abortion laws, high fertility rates, low contraceptive prevalence and lack of emergency obstetric care contribute to the elevated number of maternal deaths.

Objective This qualitative research study was conducted in multiple field sites within four provinces throughout the DRC, each with high fertility rates. This study explores the knowledge of contraception among women, community perceptions of desired fertility, barriers to contraceptive access, and the woman's contraceptive decision-making process during negotiations with the husband. This research study also sought to gain insights into abortion practices.

Methods Women of reproductive age (n=32) and reproductive healthcare providers (n=10) were purposively sampled to participate in in-depth interviews, conducted in four languages (French, Lingala, Tshiluba, and Swahili) within Equateur, Kasai-Occidental, Maniema, and North-Kivu Provinces. Participant recruitment was done through health center visits, door-to-door recruitment, and snowball and convenience sampling. After thoroughly reading the data, code development and application were employed to accurately capture the emic perspective.

Results Thematic analysis identified several key themes relating to socio-cultural influences on contraceptive use: 1) Beliefs associated with contraceptive use incorporated community perceptions along with stigmas and myths; 2) Women's lack of autonomy might be due in part to a patriarchal society; 3) Opinions of abortion practices involved counsel given to the women and the various methods used to abort.

Discussion Through examining high fertility norms, barriers to contraceptive use, and gender hierarchies**,** along with the women's lack of independence, this study concludes that Congolese women are not autonomous in decisions about fertility and family planning, and these decisions are inextricably linked to men. This study also suggests that highly unwanted pregnancies and strict abortion laws may drive Congolese women to utilize dangerous methods to induce at-home abortions resulting in abortion-related infection, complications, and fatalities.

3.3 Introduction

The Democratic Republic of the Congo (DRC) is one of the most impoverished countries, ranking 176th of 188 countries on the 2014 Human Development Index and 149th of 155 countries on the Gender Inequality Index (United Nations Development Programme, 2014b). For two decades, constant conflict, civil strife, and rampant poverty have ravaged the DRC and left pockets of insecurity throughout the vast country. The two recent wars (1996-1997 and 1998-2003) have resulted in over four million deaths and more than 50,000 incidents of sexual violence, resulting in countless unintended pregnancies (Omba Kalonda, 2008; Zapata, 2011).

The World Health Organization (WHO) defines maternal mortality as "the death of a woman during pregnancy, childbirth or within 6 weeks after birth" (World Health Organization, 2015c). According to the seven-year period before the 2013-2014 DRC Demographic Health Survey (DHS), the maternal mortality ratio in the DRC was 846/100,000 live births, more than three times the average of developing countries (Ministère du Plan et Suivi de la Mise en oeuvre de la Révolution de la Modernité (MPSMRM) Ministère de la Santé Publique (MSP) and ICF International, 2014; World Health Organization, 2015a).

The use of contraception is one solution to high maternal mortality rates, preventing high parity births, unsafe abortions, and facilitating safely spaced pregnancies. Low contraceptive prevalence coupled with high fertility rates and unintended pregnancies linked with unsafe abortion practices are all contributors to maternal mortality. Pregnancy is a fragile and complex period of any woman's life and the woman should feel empowered to make the decision to conceive a child. Consequently, Congolese women may be in positions of limited autonomy and control due to the cultural structures within the DRC, increasing difficulty in navigating the decision-making process.

3.4 Methods

To elicit the emic perspective from participants, the author used a qualitative approach. The study, spanning May 2015 – August 2015, sought to identify the perceptions of contraceptive use and the consequences of unintended pregnancy among women of reproductive age (WRA) in various provinces within the DRC. The methods used in this study are outlined below.

Study Site

In total, the study included four provinces, three districts and nine health zones. Each of these provinces had sufficient resources to identify interviewers, effectively recruit participants, and complete interviews. The structure of these provinces is further broken down into district and health zone. The provinces chosen for this study, illustrated in Figure 6, were based on a number of factors including fertility rate and programmatic motives (implementing partners (IPs), point of contacts, etc.).

Maternal mortality has been correlated with a high fertility rate, and the uptake of contraception and family planning has been shown to reduce maternal deaths (National Research Council (US) Committee on Population, 1989). Therefore, the study, excluding the active conflict zones in Eastern DRC, was conducted in the provinces with some of the highest fertility rates. The 2013-2014 DRC DHS presented Kasai-Occidental Province with the highest fertility rate of 8.2 children per woman (Ministère du Plan et Suivi de la Mise en oeuvre de la Révolution de la Modernité (MPSMRM) Ministère de la Santé Publique (MSP) and ICF International, 2014).

The practice of polygamy is also highest in Kasai-Occidental Province (Ministère du Plan et Suivi de la Mise en oeuvre de la Révolution de la Modernité (MPSMRM) Ministère de la Santé Publique (MSP) and ICF International, 2014). Statistics from West and East Africa show

that more than 20% of married women are in a polygamous relationship (Doskoch, 2013). In addition, more than 2,500 couples from a study in Malawi indicated that the contraceptive prevalence was lower among women in a polygamous marriage, when compared with women in monogamous relationships, further indicating the significance of including Kasai-Occidental in the study (Doskoch, 2013).

Three additional provinces were included: Equateur, with a fertility rate of 7.0 children per woman; Maniema, with a fertility rate of 6.9 children per woman; and North Kivu with a fertility rate of 6.5 children per woman. The provinces with the 2nd, 3rd and 4th highest fertility rates were not chosen due to their existence in the active conflict zone[1].

Study Design

The author chose a qualitative research method approach to evaluate the perceptions of contraceptive use across multiple study sites. To achieve detailed insights, in-depth interviews (IDIs) were conducted with WRA and reproductive healthcare providers (RHCPs). The one-on-one interview format helped to build rapport and encouraged participants to be open and honest.

Figure 7 simplifies the provinces, districts and health zones within which the interviews were conducted. Interviewer demographics and languages are also listed to clarify the high amount of interviewers and types of languages used. Due to the number of languages spoken throughout the DRC, the interviews were conducted in four languages: French, Lingala, Tshiluba, and Swahili. These languages were chosen based on their prevalence in each province.

Before the data collection process, the author individualized interviewer training based on language abilities and interview skills. Commonalities of the training sessions included:

[1] In November 2014, the U.S. Department of State issued a travel warning to avoid all travel to the provinces of South Kivu, North Kivu, Kasai-Orientale, and Katanga (U.S. Departmet of State - Passports and International Travel, 2015). However, in 2015, the Foreign Commonwealth Office exempted Goma in North Kivu province from the strict travel ban, allowing non-essential travel to this area (GOV.UK, 2016).

qualitative research methods overview; background on contraception and reproductive health; basic interviewer skills, including probing and follow-up questioning; and the importance of building rapport to facilitate a comfortable space for the participants. In each province, the author trained the interviewers on the characteristics of an ideal study population and stressed the importance of recruiting a variety of participants.

Study Population

Women of Reproductive Age (WRA)

The World Health Organization (WHO) defines WRA as a woman between the ages of 15-49 years of age (World Health Organization, 2016). WRA were included in the study based on participant characteristics: marital status, parity, and age. To ensure the highest participant diversity, the interviewers recruited women with varied characteristics. The study used a stratified purposive sampling approach, incorporating at least one of the following strata: post-partum women, married and unmarried women, and women with and without children. The characteristics within each stratum achieved variation and diversity among the study population.

Reproductive Health Care Providers (RHCP)

RHCPs were eligible for inclusion in this study if they had at least one consultation with a woman about obtaining contraception, ensuring some familiarity with contraceptives and the consultation process. Among the RHCPs interviewed, the study included female and male practitioners, to gain some perspective of provider gender on contraceptive use. IMA and Pathfinder International had established good working relationships with the IPs in each province resulting in high participant trust.

Participant Recruitment

Participant recruitment was achieved through health center visits, door-to-door recruitment, and snowball and convenience sampling. Due to outcomes of the initial interviews in Equateur Province, the author utilized the iterative process and altered the research design to include interviews with RHCPs in subsequent provinces. Including this population strengthened the data quality by providing context from the perspective of a trained healthcare professional.

In Kasai-Occidental Province, a special effort was made to ensure that younger women were represented in the study. In Maniema Province, door-to-door recruitment initiated a type of snowball effect, due to peaking interest from outsiders, thereby engaging interested neighbors. To achieve diversity, at most two WRA were interviewed in one neighborhood before seeking women in surrounding areas.

In North Kivu Province, the author conducted two interviews, one with each study population stratum. Convenience sampling identified participants from Heal Africa, an organization in close proximity to the IMA office in Goma.

Data Collection

The author developed and contextualized an open-ended, IDI guide for each sub-population in conjunction with thesis advisors and field supervisors [see Appendices 1 and 2]. In-country staff at the IMA office in Kinshasa and field staff in each province supported the contextualization process. Using open-ended questions versus closed questions allowed the participants to answer without leading responses (Johns Hopkins Bloomberg School of Public Health, 2015).

Through the cyclical process of redefining the study population and refining the research instrument, the initial IDI guide drafts were further edited throughout the interview process, resulting in a total of four versions per sub-population. During each province visit, the author

made minor changes to question structure and probes. After each province visit, major IDI guide edits were a result of comments during debriefing sessions, resulting in eight versions of the initial IDI guide – four for WRA, and four for RHCPs.

The author documented all changes in instrumentation and design in a comprehensive field diary containing written observations from each interview and consulted this record frequently. To maintain proper contextualization, the author conferred with a field supervisor after each alteration in IDI guide.

In each province, IPs (World Vision, SANRU, and CARITAS) located an interviewer with local language skills. The author and interviewer consistently used a common language, Swahili, to facilitate communication, complete interviewer training, and throughout debriefing sessions. The interviewers informed each participant of consent and confidentiality before each interview. Similarly, participation was voluntary and the participant was able to exit the interview at any time. The author audio recorded all interviews and the data presented have been de-identified to achieve confidentiality.

Data Analysis

Data preparation

Data collected in French and Lingala were translated during data collection. A translator listened to seven recordings and orally interpreted each part into English, while the author created the written transcript in English. This translator outsourced two of the audio-recorded Tshiluba interviews to follow the same oral interpretation and transcription process. The interviewer listened to each audio recording in Swahili and summarized the content into a written Swahili transcript. Following this, the author, with advanced Swahili language skills, translated

the content into English. The author, serving as primary interviewer in Goma, translated and transcribed verbatim two Swahili interviews into English.

Data Analysis

The author used thematic content analysis to identify core themes and patterns across the data (Boyatzis, 1998). During close readings of the transcripts, the author applied memos and used reflexivity to manage potential subjective interpretations of the data[2]. After thoroughly reading all transcripts to identify core issues, the author defined codes with examples from the transcripts to ensure consistent application, including both external deductive codes derived from the literature or theory, and internal inductive codes derived from the data itself. A comprehensive codebook was generated for reference during the coding process. After initial code development, the codes were refined during each review of the transcripts; refining code definitions, splitting codes into sub-codes, and identifying the point of saturation at which no new ideas surfaced[3].

The author applied the codes to the data using MAXQDA11, providing a framework for thematic data analysis. Using the codes the author applied the following analytic search techniques to explore the data: by single code, by topic (decision-making process, community perception, etc.), and by subgroup (WRA and RHCPs). Core themes were identified and documented in an analytic log due to their repetition in the data. The author developed thick descriptions of each theme to give each issue depth, breadth, and nuance and to describe the context in which the issues occurred.

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[2] Reflexivity is a measure of validity in qualitative research used to help minimize researcher bias and reactivity to the study itself and "must incorporate continuous awareness of reflecting, examining and exploring his/her relationship through all stages of the research process" (Kolb, 2012).

[3] In qualitative research, the point of saturation occurs when no new information is coming from the data that has not previously been noted by the researcher; the occurrence of saturation ensures sufficient information was collected to fully reflect the perspectives of the study participants (Kolb, 2012).

Constant comparison is an important tool to provide a greater understanding of the complexity of issues in the data in order to identify emergent categories (Hallberg, 2006). The author used constant comparison to further refine the description of issues in the data, e.g., community perceptions of women using contraception differed based on relationship status and number of children. The author grouped codes into categories, to conceptualize the data more clearly. The categories highlighted clearly distinct spheres of influence: beliefs associated with contraceptive use, lack of autonomy, and opinions of abortion practices.

The author validated themes such as male authority, community perception, barriers to obtaining contraception, and abortion practices by going back to the data and rerunning searches. Thematic data analysis was validated using strategies such as checking for alternative explanations and confirming that themes elicited from the data were repetitious in nature.

Ethical Considerations

The research proposal was exempted from the Emory University Institutional Review Board, as it did not meet the definition of "research with human subjects" as set forth in Emory policies and procedures. Nonetheless, the author used the following ethical procedures to protect the study participants: oral consent was obtained and information collected during the interviews was kept confidential through restriction of audio recordings to the author, interviewers and translators only. Additionally, the author de-identified all transcripts once the translation and transcription process was complete.

3.5 Results

3.5.1 Socio-Cultural Influences on Contraceptive Use and Abortion Practices

Throughout the data, social and cultural influences are interwoven within the stories of both the WRA and RHCPs. These influences played a role in the knowledge and use of contraception with an emphasis on the obstacles the Congolese women face in the decision-making process, and in the consequences relating to unintended pregnancy in the DRC.

The results are structured as follows: 1) Beliefs associated with contraceptive use – community perceptions, stigmas and myths, and level of knowledge; 2) Women's lack of autonomy – cultural and gender norms, negotiating the decision-making process, and the burden to the woman; 3) Opinions of abortion practices – counsel given to the women, community attitudes, and the various methods used to abort.

3.5.1.1 Beliefs Associated with Contraceptive Use

When asked how the community perceived a woman using contraception, thoughts are mixed. Generally, it is perplexing for a woman to use contraception under certain circumstances. To illustrate, one respondent asked, "If a woman doesn't have any children, why would she want to use contraception?" However, perceptions differ based on relationship status: 1) unmarried women, 2) married women, and 3) women with and without children.

Perceptions of Unmarried Women on Contraception

Positive views of an unmarried woman's decision to use contraception came in the form of praise for women who choose to postpone having children before finding a husband. Additional approval for contraceptive use included: protecting one's body from sexually transmitted infections (STIs), avoiding unintended pregnancies, and keeping oneself for marriage.

However, a woman mentioned that for example, even before you are married, it is good to have one child, one pregnancy to serve as proof that you are capable of having children.

Nonetheless, overall there is a negative stigma surrounding the use of contraception by unmarried women; they were likely to be criticized and rumored to be prostitutes. This idea is somewhat challenged when a woman speculated that an unmarried woman could also have a certain "bodily need." In this context, "bodily need" refers to an unmarried woman's sexual want and the fact that she uses contraception to protect herself as she further explores this sexual desire.

Perceptions of Married Women on Contraception

Married women without children using contraception are also subject to criticism and "tongue mongering," and their husbands are viewed as impotent. More generally, in this context, "tongue mongering" refers to the judgment and gossip circulating the community if anyone heard of a woman revealing that she uses contraception.

However, married women using contraception are criticized less frequently than unmarried women but only if they already had children and the number of children proved to be an important factor. For example, if a married woman only wants two or three children, she is critiqued because she is said to want to live like "white people." The advantage of more children may refer to the proof of fertility and capability of having children stated earlier, implying a connection between number of children and social status. Having two or three children would be subject to disapproval in the DRC, because as previously stated, Congolese women have, on average, six or seven children per woman. Therefore, it is acceptable for a married woman to use contraception, but even more acceptable if she has at least three children.

Perceptions of Women With and Without Children on Contraception

Women with children who use contraception are praised for: protecting their health, being able to feed their children and send them to school, and ensuring their children have a healthy childhood before they become pregnant again. Women without children who use contraception are criticized because of the belief that contraception would ruin their reproductive systems and they will never be able to have children in the future.

Of additional significance is the issue of birth spacing among women in the community. A woman recounts an instance in which a woman was evaluated based on the length of time between children:

> *If somebody doesn't have children or if there is a long spacing, people speak. Here, what is popular, after one year you should have another child. If you have a child every year, people will applaud you. So if you have a big spacing people will criticize you. – female, Bakuba, Kasai-Occidental Province*

Myths and Stigmas on Contraception

Informal conversation amongst women within the community also influences the choice of whether to use contraception. Discussions with friends about the side effects of certain methods frightened the women and discouraged them from pursuing contraception further. The women experienced side effects such as: vertigo, nausea, vomiting, weight gain or loss, and excessive bleeding. A woman heard of a friend's menstrual cycle stopping as a result of using Depo Provera and asked if there were any consequences, because, "God has created us with a monthly cycle, so you come and interrupt it, so after six months I'm just wondering if it's going to have any negative side effects?"

Also worth noting is the advice from a few of the RHCPs on the resolution of the above side effects. Tshikapa, Kasai-Occidental Province was the only site in which four RHCPs advised women who came in with severe bleeding to:

> *Take lemon juice twice a day, morning and evening, doing three days straight. Either half a glass or full glass, twice a day for three days and this resolves the problem. – female healthcare provider, Tshikapa, Kasai-Occidental Province*

Both women and RHCPs cited Implanon, Depo Provera, oral contraceptives and male condoms as the most frequently used forms of modern contraception. However, many of the women used traditional methods, mainly the calendar method. Three women reported their current form of contraception involves using male condoms and taking six doses of Paracetamol (aspirin) before sleeping with a man when they are most at risk of pregnancy; these women stated this advice came from a friend. Additional advice given to another woman led her to practice this form of contraception:

> *After being together with my partner, I can immediately remain standing for sometime thus evacuating semen from my body. That is one way we can last without me falling pregnant. And that is the method I use mostly and it worked for me. – 40-year-old female, 7 children, Mutena, Kasai-Occidental Province*

She stated that a woman from Kinshasa (the capital city) and a woman from Europe, visitors to Mutena, ran the women's meeting and educated them about this method of contraception.

Moreover, rumors about the consequences of contraceptive use include: sterility, damage to the reproductive system, and uterine cancer. Cancer was specifically associated with the use of intra-uterine devices. Speaking generally, a woman mentioned that:

> *The method closes the fertility of the woman. They say it is a poison that the white people give to the women, to kill the eggs of the fertility of the woman. – female, Alunguli, Maniema Province*

Level of Knowledge on Contraception

Interestingly, a few women and RHCPs mentioned the concept of "ignorance" as a direct barrier to acquiring contraception – mainly, ignorance of the types of methods available, and of the reasons unintended pregnancies occur. Primarily, the women asked about other methods besides the calendar method. A woman mentioned that women do not understand they could become pregnant even if they are using the calendar method and a woman recounted her personal experience with this method:

> *For the first method [calendar method], it is easy for the woman to forget about the period at risk of pregnancy. And further, to forget that I carried my first pregnancy without wanting to be pregnant. – 24-year-old female, 1 child, Alunguli, Maniema Province*

Additionally, some of the women admitted they had not gone to the health center to get contraception because they had no money to purchase contraception, yet almost all of the RHCPs specified that contraception is free. However, the RHCPs did verify that if the health center stock were low, some of the women would be obliged to purchase contraception from the pharmacy until the health center could be restocked.

Regarding knowledge about the benefits of contraception, the RHCPs had a solid understanding and adequately promoted the methods. Benefits included: avoiding maternal death, promoting birth spacing, and preventing STIs and unwanted pregnancies. The RHCPs also pointed out that the advantages of contraceptive use ultimately provide a "social benefit" for the community, state and country. In addition to the benefits listed above, a common advantage noted by the women was maintaining a strong body. The following is a remarkable example of information provided to a woman at school:

> *It is teachers who taught us our first seminar about the conversation about contraception. Yes, I chose to use Depo Provera. They came to teach us because there were so many deaths in women who were giving birth. And the second reason is there were so many deaths of girls going*

> *to have abortions [increased in volume]. And third, the reason is because many babies have died because they are born before the mother has a chance to mature after the last pregnancy. – female, Alunguli, Maniema Province*

3.5.1.2 Lack of Autonomy

According to the women, the reason unintended pregnancies occur in the DRC is because even if a wife knows she could become pregnant, her husband will say that they must have sex because he wants to. The women raised the issue of having to succumb to the husband's sexual desires or he might seek his pleasure elsewhere, and if she wanted to wait before having another child, the advice was to keep a distance from her husband. To illustrate the potential harmful situation that could ensue, a RHCP recounted a conversation with a patient:

> *So we started talking about the difficulties. She said her husband beat her up for that problem [the difficulties] and even tore off her clothes because she was not satisfying him. – male healthcare provider, Mutena, Kasai-Occidental Province*

In further discussing why women seek contraception, the same RHCP stated:

> *So this method is to protect her to avoid unwanted pregnancy and early pregnancy and to have well spaced birth. Because men don't think of that. Once he feels the sexual desire, he doesn't think about all that, he just wants to get what he wants. – male healthcare provider, Mutena, Kasai-Occidental Province*

An additional RHCP pointed out that husbands themselves are obstacles to a woman obtaining contraception or accessing reproductive health services at the health center. Husbands may not allow their wives to enter the family planning program because "they like to give birth, they like to count the children." This RHCP did warn that sometimes the husbands neglect to understand the costs of raising children, which adds up quickly and could have a great impact on the family's wellbeing. However, another RHCP stated that some women also do not agree to use contraception because they also like to give birth to many children.

Interestingly, the RHCP went further, saying that the husband's parents prefer to have many grandchildren, and sometimes they will have the greatest influence on the number of children the couple has. One recent story shared by the RHCP was about a couple that just had a baby, and both agreed to use contraception to delay another pregnancy. After an undetermined amount of time passed, the husband's parents became involved and questioned the absence of a subsequent grandchild. They asked his wife to remove the method of contraception they chose; the husband felt he must obey his parents and told his wife to discontinue the method. Although she knew she could become pregnant again, reluctantly, she agreed.

Also worth noting is that both women and RHCPs cited "religion" or "the Bible" multiple times; one RHCP explained that the church is a barrier to contraceptive use because "they [church] say contrary to what we say," and women who attend church tend not to use contraception.

According to many women, their husband's approval was required before they could go to the health center for contraception. If a wife wanted to obtain contraception despite her husband's approval, she may be forced to secretly visit the health center. Similarly, a RHCP described a consultation with a patient who clandestinely planned contraception and stated that if her husband were to find out, the marriage could end in divorce.

The idea of "no choice" is interwoven throughout the data, painting a picture of women who are powerless against their husbands, parents, in-laws and other external decision-makers. The women often mentioned that if their husbands wanted to continue having children, they must do so; "pregnancy is a part of life." A woman stated:

> *Some decide that they will only have three children. But as we last, men always go over the set number. Like we just wanted four, but we got seven. Men come towards me all the time! It's him who wants to do it to me all the time. Therefore, I have no choice. It's Biblical. I have to*

> *submit to his desire and wishes or else he might go elsewhere. – 47-year-old female, 7 children, Tshikapa, Kasai-Occidental Province*

Frequently, when the women were asked who made decisions about contraception, the usual answer was "Ni mimi mwenyewe" ("It is me myself"). However, if they make the decision to use contraception, they would first need to obtain their husbands' permission to go to the health center. Additionally, when asked who influences their decision, the women's answers varied, and included: husbands, parents, friends, and teachers; therefore, the decision-making process is unclear.

Although rare, a couple of women said they decided together with their husbands to use contraception after recognizing the "difficulties of life." They recognized that they could not afford or take care of more children and wanted to give the children they had the necessary resources so they "can survive."

The unmarried women's decision-making process is also worth mentioning. With no husband as an influence, many of these women turned to a variety of sources for guidance from their mothers, friends, and teachers.

The strain of pregnancy and childrearing proves difficult for many women, mainly in terms of health status and workload. A few of the women mentioned that the responsibility of raising children falls on the woman; one interviewee suggested this is because the husband has the opportunity to go to school. Moreover, it appears parenting often begins at a surprisingly early age:

> *When growing up, it [first pregnancy] was around the tender age of 16 or 17. But today, girls are having babies yet they don't even have breasts yet. Babies are having babies. – female, Mutena, Kasai-Occidental Province*

When asked what advice she would give to young girls, she said:

> *They shouldn't be in a hurry to be pregnant and must be very careful. Girls are now pregnant at 15! – female, Mutena, Kasai-Occidental Province*

Take into consideration this RHCPs' story about why his patient from Mutena, Kasai-Occidental Province, an area rich with diamonds, sought contraception:

> *It's just like I told you, the child is 1 month old and the woman has been beaten in her house. Her husband wanted to be with her, but the difficulties and problems she's had … "You [husband] are going to go, whoever is going to suffer it's me, so you look for your diamonds and I stay here with the children." – male healthcare provider, Mutena, Kasai-Occidental Province*

In this example, while the father is often absent, the burden of parenting falls on the mother.

A few of the RHCPs have acknowledged they are there to listen to the woman's wishes and to what she wants, not to solely follow the husband's instructions regarding contraception. RHCPs also mentioned that it is the husband's duty to support the woman through granting her permission to use contraception.

3.5.1.3 Opinions of Abortion Practices

In the context of abortion, the issue of "no choice" emerges once again. The unanimous answer from the women and RHCPs was that if a woman becomes pregnant, there is nothing she can do but accept it. The RHCPs were asked for their advice given to women who come to the health center for an abortion under two different circumstances: 1) an unmarried woman with no children, and 2) a married woman with six nearly adult children. The unequivocal recommendation was that the woman should "alinde mimba yake" ("protect her pregnancy") until it comes to term and then revisit the topic of contraception in the future.

Throughout the DRC, views of abortion are overwhelmingly negative. Abortion is denounced for a number of reasons, including religious convictions and a fear of dying, as well as the fact that it is forbidden by law and may result in the imprisonment of the woman or RHCP. The women believed that the Bible prohibits abortion because it is considered a sin and the community would condemn a married woman for seeking an abortion more than an unmarried girl. According to a woman's response, a married woman should feel guilty for having an abortion if she has a husband, although:

> *Those with no husband, they get rid of it. And they throw it on the road in that way. – female, Goma, North Kivu Province*

One particular woman stated:

> *If it [abortion] was a good thing, they wouldn't do it in hiding … the community doesn't see it as a good thing. They abort by force. But if the community hears about it, people start accusing each other and sometimes the state gets involved. – female, Bakuba, Kasai-Occidental Province*

This illustrates the severe consequences that the women and RHCPs face in obtaining or performing surreptitious abortions. Of worth noting is the idea that the woman "can be arrested because she killed someone who could have saved the community." The collective perceptions are: the child would be able to help around the house, no one can predict what the child could be someday, and the woman should "keep the pregnancy and give it to the world."

Although abortion is severely restricted throughout the DRC, both women and RHCPs in each province admitted that some of their neighbors, friends, and patients have induced an abortion. Although women of all ages may seek an abortion, it is commonly understood that younger girls are more likely to pursue the procedure. The types of methods the women used to induce abortions included the use of salt, glycerin, medicinal herbs, "white medicines," indigenous products containing roots and leaves, higher doses of unidentified pills, and self-

injections, as well as attempting to secrete or drip the uterus and bending or stooping to discontinue the pregnancy. The main place women went to obtain these methods was a pharmacy located in the local market. However, a few women mentioned that some women go to a local healer who "opened her uterus" to expel the pregnancy.

Some women from Kasai-Occidental Province did admit that they knew women who had gone to a health center to have an abortion. Nonetheless, one woman spoke of a friend who went to a health center to get an abortion, but the doctor demanded money, so she was forced to go elsewhere, putting her at higher risk of abortion-related complications and infection. In one instance, a woman specified that, "Abortion is very wrong, but the doctor who provides abortion, sees it as good because he has got money," suggesting some RHCPs benefit financially from performing illegal abortions.

Due to the potential consequences, many women were afraid to obtain an abortion. In fact, a majority of the RHCPs admitted they had received cases of unsuccessful abortions at their respective health centers, and in many of these cases, the women presented with severe infections and had to be rushed to the nearest larger medical facility. A RHCP specifically mentioned that an abortion would be ill advised due to the inadequate quality of equipment at the health center. In this example, complications from an abortion procedure resulted in a woman's death:

> *Yes, I have received a single mother who used salt to have an abortion. She came here and we took her to the hospital where she died. – male healthcare provider, Kalima, Maniema Province*

3.6 Discussion

The aim of this study was to identify the perceptions of, and obstacles to contraceptive use among women, understand the woman's decision-making process as it pertains to the use of contraception, and gain local insights into the abortion practices in a country where strict abortion laws persist. Numerous quantitative studies focus on family planning, contraception or abortion in the DRC, however a review of the literature indicates that qualitative studies on these issues are scarce. This is one of the few studies of its nature to investigate influences on the uptake of contraception and factors influencing abortion practices among women in the DRC.

Through examining fertility norms, barriers to contraceptive uptake, and gender roles and disparities, along with the women's level of independence this study provides contextual information and offers valuable evidence of the social and cultural influences affecting the decisions pertaining to contraceptive use and access. This study concludes that Congolese women are not autonomous in decisions about fertility and family planning, and these decisions are inextricably linked to men; illustrating examples of how multiple intersecting domains of influence affect the woman's decision and ultimately her right to choose to use contraception.

Through investigating community attitudes of abortion, current abortion practices, and the methods a woman may use to abort, this study suggests that firm abortion laws may drive Congolese women to use dangerous methods to perform at-home abortions resulting in abortion-related complications and fatalities.

Contraceptive Uptake among Women

This study found some prominent barriers: community perception, gossip, husband opposition, religious beliefs, and the idea of contraception as a white custom. Some of the barriers identified in this study were consistent with obstacles presented in a cross-sectional

study conducted in Vanga (Western DRC), which included fears of infertility and side effects, husband's resistance, and religious principles (Izale et al., 2014). However, findings from this study identified additional barriers such as: stigmas associated with prostitution, the need to satisfy the husband's sexual desires, and the significant authority held by the male partner's parents.

This study illustrates that the decision-making process and the diverse influencers could complicate the woman's use of contraception. Influential factors such as voicing stigmas associated with contraceptive use, concerns about Congolese women following a white tradition, and the expectation of giving birth to multiple children should all be considered in understanding how these affect the woman's decision of whether to use contraception. While there were mixed perceptions about contraceptive use in this study, the fact that women were frightened and subsequently did not seek contraception due to informal conversations within the community illustrates the ease with which one woman's adverse encounter while using contraception could further influence contraceptive uptake among friends and neighbors. This study appears consistent with a quantitative study in the DRC, which measured friends as a common source of information (50%), but due to the perceptions listed above, is inconsistent with findings signifying 80% of the women perceived family planning as good (Mathe, Kasonia, & Maliro, 2011).

The low status of women in the DRC indicates that women lack the power necessary to make decisions pertaining to their reproductive health. The findings from this study suggest targeted education for Congolese men is necessary to educate them about the benefits of contraception for their wives, sisters, and friends. While there is a plethora of literature available on women's empowerment strategies in the DRC, evidence from this study concludes the

necessity to supplement this empowerment with male education. Empowering women to feel in control of their situations along with educating men about the burden of pregnancy and childrearing are crucial steps in securing the attainment of Congolese women's reproductive rights.

As the results indicate, it is apparent that gender norms play a distinct role in fertility and reproduction and while men may bear the financial responsibility of children, the duty of caring for the children falls on the woman. While a majority of the women identified that they themselves make the decisions, they also said that their parents, friends and teachers influenced them and they had to ask the husband's permission. Therefore, it appears that while women may make the initial decision to use contraception, the male figure may hold the power to make the final decision. In many cases, husband permission to obtain contraception was mandatory, and those unable to attain this authorization were unable to further pursue contraception.

Due to some women's experiences in stating the questionable efficacy of the calendar method, it is important to understand the consistency with which this method is taught in schools throughout the DRC. Specifically, further research amongst teachers at schools is needed to ascertain the effectiveness, validity and accuracy of the information provided. Mathe et al. measured the women's awareness of their fertile period, of which 68% were aware, but only 35% could accurately note the exact fertile period (Mathe et al., 2011). This appears to be consistent with the general responses from the women in this study pertaining to their experiences with the ineffectiveness or misuse of the calendar method.

While some women either used the calendar method or did not use any form of contraception, evidence that some of the women use modern contraception does illustrate a potential shift in cultural acceptability towards these methods. This finding is somewhat

consistent with discoveries from a study conducted by Audu et al. suggesting that the use of traditional methods among married WRA in Nigeria meant contraception was considered a cultural norm, but perhaps the resistance to modern contraception was due to its unfamiliarity amongst the community (Audu, Yahya, & Bassi, 2006).

Even though a majority of the women live close (within 1KM) to the health center, for those not using modern contraception, knowledge of methods available besides the calendar method was extremely low. This is consistent with one study in a large city in Eastern DRC stating a majority of those surveyed used the calendar method, demonstrating the need for further community education about the types of modern contraceptive methods available (Mathe et al., 2011).

Abortion Practices in the DRC

Abortion is illegal and few researchers have investigated this issue in the DRC; however, the following three studies are worth mentioning. A study in Bukavu, DRC focused on evaluating the reduction of back-street abortions due to the activation of family planning programs (Mibi Kakisingi, 2012). In the context of sexual violence, a related study argues for decriminalizing abortion in the DRC due to the high number of unintended pregnancies and the occurrence of unsafe abortions that contribute to maternal deaths (Kalonda, 2012). An additional study by Kisindja et al. described the presentation of first trimester abortions in the DRC and concluded that induced abortions are an important problem and additional information is required to understand the prevalence of clandestine abortions (Kisindja, 2012).

In light of women deciding to pursue an abortion in this study, advice given to the women to keep the pregnancy suggest that the woman will not pursue alternative and potentially fatal ways of having the abortion. Furthermore, the strict Congolese abortion laws should

discourage the frequency of illegal abortions, yet this research shows that for a multitude of reasons, women across the DRC seek abortions using numerous unsafe methods. Therefore, two dilemmas arise: accept the responsibility of raising an additional child, or pursue an unsafe abortion with potentially fatal consequences.

Reproductive Healthcare Provider Perspective on Contraception

Findings from this study regarding RHCP knowledge are consistent with other literature. Whereas many RHCPs understood the consultation process and the advantages of contraception, when counseling the women on how to mitigate the side effects of contraception the advice was not always accurate. These findings show the need to provide RHCPs with additional education to equip them with the knowledge to correctly counsel the women.

The extremely religious nature of the DRC brands both contraception and abortion as sensitive subjects. Religion as a barrier to contraceptive uptake among women is illustrated by the RHCP responses indicating the teachings of the church oppose the advice of the RHCP. Therefore, additional research on the impact of religion in this context would further strengthen the topic of contraception (Izale et al., 2014).

Strengths and Limitations

This study has several limitations. Over 200 native languages are spoken in the DRC and to elicit the best quality of data possible, the interviews were conducted in the participant's local languages; a combination of French, Lingala, Tshiluba, and Swahili. However, with this many languages, the author had difficulties finding qualified Tshiluba-English translators to transcribe the interviews verbatim, resulting in two out of seven Tshiluba transcripts from Kasai-Occidental Province.

Interviewers in each province and field site were chosen based on availability, thus occasionally the interview process lacked continuity. Additionally, the extent of interviewer training was completed as time permitted, introducing the possibility of imperfect interviewer training in how to effectively conduct in-depth interviews.

Much of the previous research conducted in the DRC has been quantitative in nature. A great strength of this study was being able to elicit a wide variety of perspectives from WRA and RHCPs in four different provinces, and in many cases, multiple field sites within each province. This study also contributes honest opinions to the sparse qualitative data pertaining specifically to the issues of contraceptive use and abortion practices in the DRC. As most research in the DRC has been completed in Eastern DRC, another great strength is that this research was conducted in diverse provinces in Northern, Southern and Eastern DRC.

The limitations are not insignificant and should be considered when forming conclusions about the findings presented. However, the data suggest the need to explore these influences further within the Congolese context.

Chapter 4. Conclusion and Recommendations

Congolese women are subject to negative consequences of sexual violence and rape resulting from ongoing civil conflict, restricted autonomy in the contraceptive decision-making process, disproportionate childrearing responsibilities, and a high maternal mortality rate. Women living in the DRC, a country denounced as "the worst place in the world to be a woman" and renowned for its international title as the "rape capital of the world," deserve more (Human Rights Watch, 2009; Nanivazo, 2012). Congolese women lack basic reproductive rights along with the access to safe and legal abortion, rights that have been granted to women across the world for decades.

This study illustrates how male authority in the Congolese culture is both a symptom of and a catalyst for change in the social and cultural acceptance of contraceptive use among Congolese women. Moreover, progressive advocacy in sexual and reproductive rights and abortion practices are needed in the DRC. Thus, considering the subsequent recommendations, it is evident that small, yet essential steps can be taken to provide hope and allow the opportunity for Congolese women to take control of their reproductive health.

In the future, the advancement of Congolese women's reproductive rights will rely, in part, upon studies examining men's perceptions of contraceptive use and abortion practices. Perspectives from both genders will significantly complement the findings of this study and enhance the ability to advocate for mutually recognized, evidence-based interventions. Enlisting male involvement as advocates of women's reproductive rights is also essential in creating an atmosphere that holistically promotes the health of the woman.

The following two studies illustrate documentation of the need to increase male participation across Africa. The first study conducted in Ethiopia sought to explore the current level of male involvement in family planning services, concluding male participation was low

due to the wish to have more children along with lack of information and access to the services (Kassa, Abajobir, & Gedefaw, 2014). Likewise, results from a qualitative study conducted with providers in Kenya identified that males have historically been a prohibiting factor in women accessing family planning services, and described several benefits of male partner inclusion (Tao et al., 2015).

To meet Congolese women's need for reproductive autonomy, policies and programs to promote gender equality and inspire the woman's freedom in the decision-making process should be conceptualized and implemented. In response to the weight of male authority on women's use of contraception, empowerment strategies will provide women the control to advocate for their own reproductive health and desires.

In addition to the influence of male authority, religious principles serve as a barrier to women's use of contraception. Religion is a fundamental element of many people's lives, and the intersection of religion and reproductive health has historical underpinnings in the DRC. As shown by this research, the Bible and certain religious beliefs guide some women to refrain from contraceptive use and perpetuate criticisms of women who choose to use contraception. To further understand the impact of religion on contraceptive use, future studies aimed at this crossroad are necessary. To engender social change, it is essential that these strategies include an element of religious engagement and incorporate two vital components: motivating women to *negotiate* sexual activity and encouraging women's autonomy to freely access and use contraception without control of religion.

Strategies addressing the male perspective, women's autonomy, and religion will contribute to effective reduction in the number of unintended pregnancies in the DRC. Giving women the agency to access contraception will likely decrease the number of Congolese women

seeking illegal abortions. Regrettably, unless attention is drawn to the current state of unsafe abortion practices among women in the DRC, obtaining the procedure will remain illegal and continue to provoke condemnation. As shown by this research, women are utilizing unsafe measures to perform dangerous and life-threatening abortions because abortion is illegal. Government officials and policy makers hold the power to amend abortion policy; therefore, advocacy campaigns targeting these leaders is critical. Policy and programmatic experts also need to reevaluate the current abortion law and make legislative changes, to promote a reduction in maternal mortality from abortion.

Fertility and abortion ideologies must evolve. The constant sociopolitical and moral struggles inherent in these issues contribute to the historical lack of progress, and it is the responsibility of public health professionals to fight to advance reproductive rights. By advocating for the rights of Congolese women to choose their own reproductive paths, the future of Congolese women's health can be attained and fundamental changes can begin to occur. The Congolese women say it without saying it: *It is time we are noticed.*

Tables and Figures

Figure 1: **The consequences of low contraceptive use, resulting in maternal mortality.**

Figure 2: **The Democratic Republic of the Congo, Central Africa (Central Intelligence Agency, 2016).**

Figure 3: **Size Comparison: The United States versus the Democratic Republic of the Congo, Central Africa (Collins, 2016).**

Figure 4: **Modern contraceptive rate by province in the DRC (Ministère du Plan et Suivi de la Mise en oeuvre de la Révolution de la Modernité (MPSMRM) Ministère de la Santé Publique (MSP) and ICF International, 2014).**

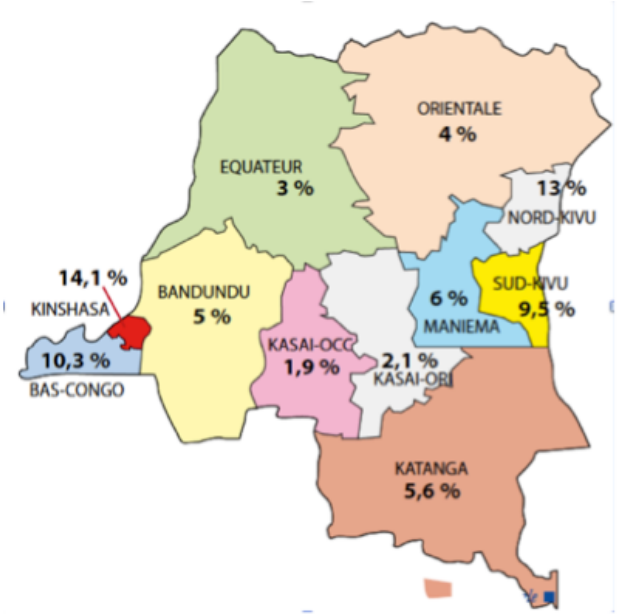

Figure 5: **Flow chart of organizational structure in the DRC.**

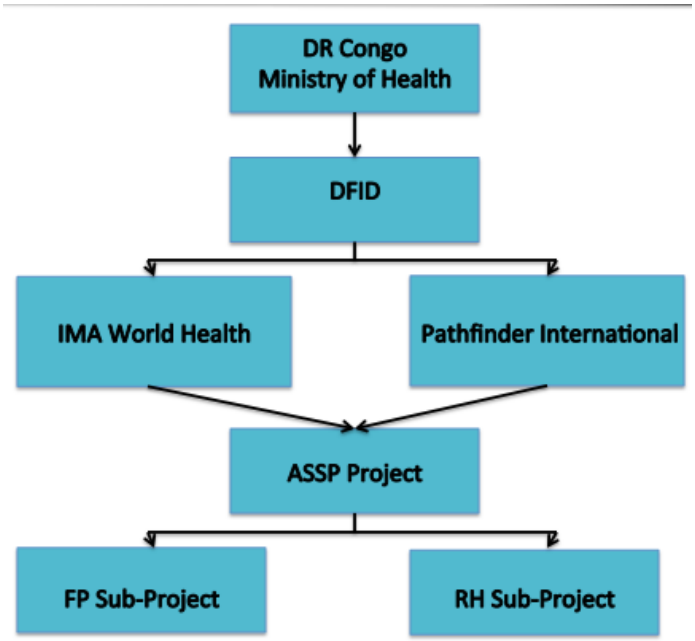

Figure 6: **Political Map of the Democratic Republic of Congo – modified to illustrate the provinces travelled to in this study (Ezilon Maps, 2015).**

Figure 7: **Breakdown of IDIs: Summary of place, number of interviews, interviewer demographics and languages used to conduct interviews. RHCP: healthcare provider, WRA: woman of reproductive age.**

Province	District	Health Zone	Number of Interviews	Interviewer Demographics	Languages Used
Gbadolite	North Ubangi	Gbadolite	WRA: 5 RHCP: 0	1 female, American 1 female, Congolese	French and Lingala
Kasai-Occidental	Kasai	Tshikapa	WRA: 5 RHCP: 2	1 female, Congolese	French, Lingala, and Tshiluba
		Kanzala	WRA: 4 RHCP: 2		
		Bakuba	WRA: 2 RHCP: 1		
		Mutena	WRA: 1 RHCP: 1	1 female, Congolese 1 male, Congolese	
Maniema	Kindu	Kalima	WRA: 5 RHCP: 1	1 male, Congolese	Swahili
		Alunguli	WRA: 4 RHCP: 1		
		Kindu	WRA: 5 RHCP: 1		
North Kivu	N/A	Goma	WRA: 1 RHCP: 1	1 female, American	Swahili
Total	**3 Districts**	**9 Health Zones**	**42 Interviews**	**7 Interviewers**	**4 Languages**

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APPENDIX

1. In-Depth Interview Guide – Women of Reproductive Age (Latest Version)

IDI Guide: Women of Reproductive Age
IDI Guide: les femmes en âge de reproduction

Questions de recherche: Les facilitateurs et les obstacles à l'utilisation de la contraception parmi les femmes : une étude à mener a' Equateur, au Kasaï occidental et dans la province du Maniema en république Démocratique du Congo

Research Question: Facilitators and barriers to contraceptive use among women: A study in Equateur, Kasai, and Maniema Provinces in the Democratic Republic of Congo.

Introduction:

I appreciate the opportunity to speak with you today. My name is _____ and I will be the interviewer. This is my colleague, _____. This interview is part of Jennifer's Master's in Public Health research at Emory University in the United States. The project is overseen by Pathfinder International and in partnership with IMA World Health. This project seeks to understand why some women decide to use family planning methods, and why some don't here in _____ (Town, Province). After this interview, I will then use the information to suggest ideas for IMA World Health. These ideas will be implemented at the health centers with the hopes of increasing the number of women who use contraception.

Je suis très contente de saisir cette opportunité de parler avec vous aujourd'hui. Je m'appelle----------et je serai la personne qui va guider cette interview. Je vous présente ma collègue Jennifer. Cette interview fait partie de la recherche du Master en Santee publique à l'université de Emory en Etats Unis d'Amériques. Le projet de cette recherche est supervisé par pathfinder International en partenariat avec IMA World Health. Le projet voudrait comprendre comment certaines femmes décident facilement d'utiliser les méthodes contraceptives, et d'autres n'accedent ici a Tshikapa. Apres cette interview, je vais saisir l'opportunité d'exploiter les informations collectées pour partager avec IMA World Health en vue d'améliorer l'utilisation des services de la planification familiale au niveau de structures de soins bénéficiaires de l'appui du projet ASSP.

Your personal stories and thoughts are very important to this research, and your participation is greatly appreciated. Your individual experiences, opinions and beliefs are the most useful information you can provide.

Votre propre histoire et vos idées sont très importantes pour l'atteinte des objectifs de cette recherche, ainsi votre participation active est vivement attendue. Tes expériences individuelles, tes opinions, ainsi que tes convictions sont de très enrichissantes informations à partager avec nous.

All of the information you provide will be treated as private and confidential. Throughout the interview, your identity will be protected. Your name and other identifying information will be excluded from notes, transcripts, and reports. Your participation is completely voluntary and if you wish to discontinue the interview at any time, feel free to stop.

Toutes les informations que tu vas mettre à notre disposition seront traitées avec respect confidence. A travers cette interview, votre identité sera protégée. Votre nom et les autres identifiants liés à votre personne seront exclus de différentes notes, transcriptions et rapports. La participation à cette étude est complètement volontaire et sans payement. Si tu as des attentes pour un payement quelconque, nous pouvons arrêter l'interview à n'importe quand, et sentez-vous libre de l'exprimer quand vous voulez.

The interview will not take more than 1 hour. I would like to tape record our interview so I can revisit the interview for accuracy. I will also be taking notes to remind me of additional questions I may want to ask you as the interview begins. Do I have your permission to tape record our session? (Make sure she gives consent to audio record.)

L'interview ne prendra pas plus d'une heure. L'interview sera enregistrée pour nous permettre de réécouter l'interview pour l'exactitude des informations collectées. Je vais aussi la prise des notes pour me permettre de me rappeler de questions additives a l'interview et aussi mentionner fixer les éléments essentiels et improvisés qui ressortent au cours de l'interview. Puis je avoir votre permission pour mettre l'enregistreur en marche pour commencer notre interview ? (soyez *sure qu'elle a donné son consentement pour enregistrer l'interview).*

Feel free to ask any questions you have at any time. Additionally, if there are any questions you would prefer not to answer, please let me know and we can skip those and move on.

Soyez libre de poser et à n'importe quel temps des questions, ainsi s'il y a des questions auxquelles vous ne voulez pas répondre faites le moi savoir, nous pouvons les sauter et avancer d'une manière consensuelle.

Do you have any questions for me before we get started?

Avez-vous une question pour moi avant que l'on commence l'interview proprement dite?

Warm Up Questions:

1	How old are you?	**Quel âge avez-vous?**
2	Where are you from?	**D'où venez-vous?**
3	Where do you currently live?	**Ou habitez vous actuellement?**
4	Do you have a man in your life?	**Actuellement, avez vous un homme dans votre vie?**
5	How many children do you have?	**Combien d'enfants avez-vous?**
6	How old were you when you gave birth to your first child?	**Quel âge aviez-vous lorsque vous avez donné naissance à votre premier enfant?**
7	What do you do in your life?	**Que faites –vous dans la vie?**
8	Do you live far from the health center?	**Vivez-vous vivez loin du centre de santés?**
9	What is the distance, in kilometers, between your house and the health center?	**Quelle est la distance, en kilomètres, entre votre maison et le centre de santé?**

Key Questions:

General Attitudes Toward Reproduction

10	What do you think is a good age to get pregnant? a. Why?	**A votre avis quel est le meilleur âge pour tomber enceinte ?** **a. Pourquoi ?**
11	How much time do you want between two pregnancies? a. Why?	**A votre avis il faut combien de temps entre deux grossesses** **a. Pourquoi ?**
12	Are you currently using any form of contraceptives? a. Probe: i. If you don't do anything, then why? ii. If you do something, then what is it that you do?	**Est-ce que actuellement vous utilisez une méthode contraceptive modern?** **i. Si vous n'utilisez pas une méthode, pourquoi?** **ii. Si vous utilisez une méthode, ou une forme de la contraception laquelle?**
13	In the past what did you do to not get pregnant? a. Probe: i. Which method did you use? ii. Who did you talk to? iii. What information did you receive? iv. Was this information adequate? v. If your current form of contraception is different from the first form you used, why did you change?	**Dans le passé qu'avez-vous fait pour ne pas être enceinte?** **i. Quelle méthode avez vous utilise?** **ii. A qui est-ce-que vous avez parlé ?** **iii. Quelles informations avez-vous obtenues?** **iv. Est-ce que les informations reçues t'ont aidée?** **v. Si l'actuelle méthode contraceptive que vous utilisez est différente de celle utilisées autrefois, pourquoi ce changement?**

Decision-making

14	Who in your life influences your decisions about using contraception? a. Probe: Mother, father, husband, aunt, uncle, friends, teachers, religious leader. i. Why do they influence you?	**Dans ta vie qui t'a influence afin d'utiliser la contraception?** **Sondage: La maman, papa, Mari, enseignants, tante, oncles, leaders religieux, amis** **i. Pourquoi ils vous influencent-ils?**
15	How do you make decisions about using contraception? a. Probe: ii. Who is in charge? ii. How does the conversation with the decision-maker go?	**Comment vous prenez la décision sur l'utilisation des méthodes contraceptives?** **i. Qui prend la décision d'utiliser ces méthodes?** **ii. Comment les négociations se passent avec la personne qui vous prend en charge?**
16	Personally, what do you think are the main barriers to acquiring contraception? ii. Probe: i. Why are these barriers?	**Personnellement quelles sont pour vous les barrières à l'utilisation des méthodes de contraception:** **i. Pourquoi ces barrières?**
17	At the health center, is there a fee for getting contraception? a. Probe: i. If so, how much is the fee? ii. Does the price differ depending on the method?	**Au centre de santé, est -il des frais pour obtenir la contraception ?** **i. Si oui, combien sont les frais ?** **ii. Est-ce que le prix diffère en fonction de la méthode ?**

Community Perception

18	How do you think people in this community feel about women who use contraception? a. Probe: i. Describe what people in the community think about married women who use contraception. ii. Describe what people in the community think about unmarried women who use contraception. iii. Describe what people in the community think about women with children who use contraception. iv. Describe what people in the community think about women without children who use contraception.	**Que pense la communauté pour une femme qui utilise les méthodes contraceptives?** **i. Décrivez comment les gens pensent quand une femme mariée utilise des méthodes de contraception en étant marié.** **ii. Décrivez comment les gens pensent quand une femme non mariée utilise des méthodes de contraception en étant non marié.** **iii. Décrivez comment votre communauté pense d'une femme qui a des enfants et qu'utilise des méthodes de contraception.** **iv. Décrivez comment est ce que la communauté pense lorsqu'une femme qui n'a pas d'enfants utilise des méthodes de contraception.**
19	In the community, are any stigmas about contraception? a. Probe: i. If so, what are these stigmas? ii. Why do these stigmas exist?	**Dans la communauté , sont des stigmates sur la contraception ?** **i. Si oui, quelles sont ces stigmates ?** **ii. Pourquoi ces stigmates existent ?**

Abortion

20	Sometimes women get pregnant when they don't want to be, and they get rid of the pregnancy. If that happens here, what do women do?	**Quelque fois une femme n'as pas désiré la grossesse, et elle tombe enceinte, mettre fin à sa grossesse, qu'est-ce que vous faite ici chez vous?**
21	What are the communities' attitudes toward abortion? a. Probe: i. Why do you think they feel that way?	**Quelles sont les attitudes/ perceptions de la communauté sur l'avortement?** **Sondage:** **i. Pourquoi la communauté affiche ces attitudes la?**
22	If a friend with one child wanted to wait before having another child, but becomes pregnant anyway, what would you advise she do? a. Probe: i. Why would you tell her this?	**Si tu as une amie qui a déjà eu un enfant, et tient à pratiquer l'espacement optimal de naissances, mais devient enceinte de toute façon, qu'est-ce que tu peux lui donner comme conseil?** **i. Pourquoi tu lui diras cela ?**
23	What problems do you think she might encounter in delaying another pregnancy?	**Quelle probleme penses tu qu'elle aura s'elle compte repousser une autre grossesse?**
24	Have you heard of women using a dangerous method to get an abortion? a. Probe: i. Please describe this dangerous method.	**Avez-vous entendu parler de femmes utilisant une méthode dangereuse pour obtenir un avortement ?** **i. S'il vous plaît décrire cette méthode dangereuse.**

Closing Questions:

25	Is there anything else you'd like to share?	**Avez-vous quelque chose autre à partager avec moi?**
26	Do you have any questions for me?	**Avez-vous une autre question pour moi?**

Thank you for your honest answers and participation!

Merci beaucoup pour vos réponses et participation!

2. In-Depth Interview Guide – Reproductive Health Care Provider (Latest Version)

IDI Guide: Health Care Providers

IDI Guide: pour prestataires cliniques

Questions de recherche : Les facilitateurs et les obstacles à l'utilisation de la contraception parmi les femmes : une étude à mener a' Equateur, au Kasaï occidental et dans la province du Maniema en république Démocratique du Congo

Research Question: Facilitators and barriers to contraceptive use among women: A study in Equateur, Kasai, and Maniema Provinces in the Democratic Republic of Congo.

Introduction:

I appreciate the opportunity to speak with you today. My name is _____ and I will be the interviewer. This is my colleague, _____. This interview is part of Jennifer's Master's in Public Health research at Emory University in the United States. The project is overseen by Pathfinder International and in partnership with IMA World Health. This project seeks to understand why some women decide to use family planning methods, and why some don't here in _____ **(Town, Province)**.

Je suis très ravie d'avoir cette opportunité de parler avec vous aujourd'hui. Je m'appelle---------- et je suis la personne qui va jouer le rôle de vous interviewer. Celle – ci est ma collègue Jennifer. Cette interview fait partie de la recherche en Santee publique de son diplôme de Master à l'université de Emory en Etats Unis d'Amériques. Le projet de cette recherche est supervisé par pathfinder International en partenariat avec IMA World Health. Ce projet de recherche à comprendre comment certaines femmes décident facilement à utiliser les méthodes contraceptives, et comment les autres femmes ici a Tshikapa n'accèdent pas à la contraception.

I am most interested in the type of information given to the women, the way the information is portrayed, the different contraceptive methods available here at the health center, and facilitators and barriers to contraceptive use. I will then use this information to create interventions for IMA World Health. These interventions will be implemented at the health centers with the intention of increasing the number of women who use contraception.

Je suis très intéressée par connaitre le type d'information que vous donnez aux femmes, la manière l'information est présentée, et même décrite, les différentes méthodes contraceptives disponible ici au centre de santé, les facilitateurs et les barries a l'utilisation de méthodes contraceptives. Je veux également utiliser les informations collectées pour stimuler les interventions auprès de IMA World Health. Les interventions seront mises en œuvre aux centres de sante beneficiaires de l'appui du projet ASSP avec l'intention d'augmenter le nombre de femmes qui utilisent les methodes contraceptives modernes.

Your stories and thoughts are very important to this research, and your participation is greatly appreciated. All of the information you provide will be treated as private and confidential. Throughout the interview, your identity will be protected. Your name and other identifying information will be excluded from notes, transcripts, and reports. Your participation is completely voluntary and if you wish to discontinue the interview at any time, feel free to stop.

Ton histoire et tes pensées sont très importants pour cette recherché, et ta participation soutenue

est appréciable pour atteindre les objectifs de cette étude. Toutes les informations que tu donnes seront traitées avec respect et confidence. Ton identité sera strictement protégée, et ton Nom et autres identifiants de ta personne seront exclus de notes et rapports relatifs à cette étude. Ta participation est complètement volontaire, et si tu préfères rompre l'interview tu peux le faire à tout moment, et sois libre de le faire.

The interview will not take more than 1 hour. I would like to tape record our interview so I can revisit the interview for accuracy. I will also be taking notes to remind me of additional questions I may want to ask you as the interview progresses. Do I have your permission to tape record our session? *(Make sure she gives consent to audio record.)*

L'interview ne prendra pas plus d'une heure. L'interview sera enregistrée pour nous permettre de réécouter l'interview pour l'exactitude des informations collectées. Je vais aussi la prise des notes pour me permettre de me rappeler de questions additives a l'interview et aussi mentionner fixer les éléments essentiels et improvisés qui ressortent au cours de l'interview. Puis je avoir votre permission pour mettre l'enregistreur en marche pour commencer notre interview ? (soyez *sure qu'elle a donné son consentement pour enregistrer l'interview).*

Feel free to ask any questions you have at any time. Additionally, if there are any questions you would prefer not to answer, please let me know and we can skip those and move on.

Soyez libre de poser et à n'importe quel temps des questions, ainsi s'il y a des questions auxquelles vous ne voulez pas répondre faites le moi savoir, nous pouvons les sauter et avancer d'une manière consensuelle.

Do you have any questions for me before we get started?

Avez-vous une question pour moi avant que l'on commence l'interview proprement dite?

Warm Up Questions:

1	What is your role at the health center?	**Quel est votre rôle dans ce centre de santé?**
2	In general, how much training do health care workers in your position receive?	**En général, combien de formations un infirmier de votre position doit nécessairement avoir?**

Key Questions:

3	What are some characteristics of the women who come to the health center? a. Probe: i. Married, unmarried? ii. Are they alone? iii. What is the husband or partner's involvement?	**Quelles sont les caractéristiques de femmes qui fréquentent votre centre de santé ?** **i. Mariées, non mariées** **ii. Elles arrivent toutes seules ?** **iii. Quel est le rôle du mari o partenaire ?**

Dissemination of Information

4	When a woman comes to the health center asking about how to prevent pregnancy, what do you tell her?	**Quand une femme arrive au centre de santé pour prévenir une grossesse non voulue, qu'est ce vous lui dites?**

5	What kinds of contraception are available at this health center?	**Quels types de contraceptifs sont ils disponibles à votre centre de sante**
6	Have you had consultations with women about contraception?	**Avez-vous eu des consultations avec les femmes sur la contraception ?**
7	Please walk me through a normal consultation with a woman seeking contraception.	**S'il vous plait pouvez m'expliquer comment se déroule une consultation normale d'une femme désirant une méthode contraceptive modern?**
8	When informing a woman about her options, how do you portray that information? b. Probe: i. Informational brochures, posters, verbally, etc.	**Quelles informations vous donnez a la patiente sur la méthode de contraception qu'elle a choisi? comment l'information est décrite/ et ou présentée?** **i. Brochure d'information** ii. **Affiche ou poster, verbalement etc…**
9	In your opinion, do you have adequate resources to educate the women about their choices? a. Probe: i. Why or why not?	**Pensez-vous avoir des informations suffisantes pour orienter et conseiller correctement les femmes sur leurs choix ?** **i. Pourquoi ou pourquoi pas?**

Types of Methods Used

10	For the women coming to this health center, what is the most common method they use to prevent pregnancy? c. Probe: i. Why do you think this method is most common?	**Pour les femmes qui frequentent votre centre de santé, quelle est dans l'ensemble la méthode la plus utilisée pour prévenir les grossesses ?** **i. Pourquoi tu penses que cette méthode est la plus utilisée ?**
11	Is there enough of each method in stock at this health center?	**Est-ce que il y a un bilan suffisant de chaque méthode à ce centre de santé?**
12	At the health center, is there a fee for getting contraception? b. Probe: i. If so, how much is the fee? ii. Does the price differ depending on the method?	**Au centre de santé, est-il des frais pour obtenir la contraception ?** **i. Si oui, combien sont les frais?** **ii. Est-ce que le prix diffère en fonction de la méthode?**
13	What are the benefits of contraception?	**Quels sont les avantages de la contraception?**
14	If you see side effects in women using contraception, what are those side effects? a. Probe: i. What method has the most mentioned side effects? ii. What do you recommend they do to resolve the problem(s)?	**Depuis que vous consultez les femmes qui utilisent differentes methodes de contraception, quelles sont les effets secondaires que vous avez répertorié** **i. Quelles est la méthode la plus considérée comme ayant plus des effets secondaires ?** ii. **Qu'est-ce que vous recommandez aux femmes avec des effets secondaires pour résoudre leurs problèmes ?**
15	In your opinion, are there any barriers to a woman	**Pensez vous qu'il y a des barrières qui**

	obtaining contraception or accessing family planning services? d. Probe: i. What are these barriers? ii. Why do these barriers exist? iii. How do we overcome these barriers? iv. IF THERE ARE NO BARRIERS, does this mean you think every woman has an equal chance of getting contraception?	**empêchent la femme à avoir une méthode contraceptive/ ou accéder aux services de planification familiale** **i. Quelles sont ces barrières ?** **ii. Pourquoi ces barrières existent ?** **iii. Comment faire face a ces barrières ?** **iv. SI Il N'Y A PAS DE BARRIERES , ce que cela signifie que vous pense que chaque femme a une chance égale d'obtenir la contraception?**
16	If a woman comes to you with problems about contraception, do you offer them counseling? a. Probe : i. Please describe how you counsel them.	**Si une femme vient à vous avec des problèmes au sujet de la contraception, ne vous leur offrez des conseils ?** **i. S'il vous plaît décrire comment vous conseiller.**

Decision-making

17	In your opinion, why do women look for contraception?	**À votre avis, pourquoi les femmes recherchent pour la contraception?**
18	Who do you think influences the woman's decision about using contraception? a. Probe: i. Why do you think this person is so influential?	**Qui pensez-vous influence la décision de la femme sur l'utilisation de la contraception ?** i. **Pourquoi pensez-vous que cette personne est très influente pour la contraception?**

Abortion

19	If a young unmarried woman becomes pregnant and wants to end the pregnancy, what would you tell her?	**Si une femme non mariée (contracte une grossesse non voulue) devient enceinte et pense mettre fin à sa grossesse, qu'est-ce que tu peux lui dire?**
20	If a married mother with six nearly adult children become pregnant and wants to end the pregnancy, what would you tell her?	**Si une femme mariée avec six grands enfants contracte une grossesse et veut mettre fin a cette grossesse, qu'est-ce que tu peux lui dire?**
21	If a woman comes into the health center asking about an abortion, what would you tell her?	**Si une femme vient te consulter pour demander un avortement, qu'est-ce que tu peux lui dire?**

22	What do you think about abortion? a. Probe: i. Why do you think this way? ii. Have you received cases of abortions? iii. How do you take care of them? iv. What counseling do you give to them? v. If a woman has had an abortion, what did she use to get the abortion?	**Que pensez vous de l'avortement ?** **Sondage :** **i. Pourquoi** **ii. Avez vous deja enregistree des cas d'avortement** **iii. Comment prenez vous en charge ces cas** **iv. Quel conseil donnez vous a ce genre de patiente** **v. Si une femme a eu un avortement , qu'est-ce qu'elle utiliser pour obtenir l' avortement?**

Closing Questions:

23	What do you think is most important for women to know about using contraception?	**A votre avis qu'est ce qui est important pour la femme de connaître sur la contraception?**
24	Is there anything else you'd like to share?	**Avez-vous autres chose a partager avec moi?**
25	Do you have any questions for me?	**Avez-vous une autre question pour moi?**

Thank you for your honest answers and participation!

Merci beaucoup pour votre honnêtes réponses et participation!