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## **Exploring the Deep-rooted Social Norms that Affect Demand for and Use of Modern Contraceptive Methods in Ugandan Communities**



### **Social Norms Exploration Final Report**

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## List of Acronyms

APC	Advancing Partners & Communities
EBCD	Experience-based Co-design
FP	Family Planning
HC	Health Center
HW	Health Worker
JSI	John Snow, Inc.
SNE	Social Norms Exploration
SRH	Sexual and Reproductive Health
USAID	U.S. Agency for International Development
VHT	Village Health Team

## Definitions of Key Terms

**Community co-design process:** The process of involving the target community in designing its own intervention to solve identified issues or problems.

**Exploration:** A systematic way of searching within an area of interest to learn more about it, discover new information, and broaden understanding of the subject studied.

**Experience-based co-design:** A user-centered approach that enables users, potential users, providers, and other stakeholders to co-design services and service delivery pathways in partnership. This way, the community owns the intervention.

**Low-parity women:** Women who have given birth to fewer than three children. Uganda's fertility rate is at 5.4 children per woman; hence, fewer than three children is lower than average.

**Social norms:** A set of conformant ideas that represent a group's shared beliefs about what other people do, and their shared expectations about what they should and should not do.

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## Executive Summary

Advancing Partners & Communities (APC) is a U.S. Agency for International Development (USAID)-funded global project that supports and advances community programs that focus on family planning (FP). Uganda has various religions, cultures, norms, and traditions across its regions that influence human behavior at the community level and the use of modern contraceptives.

APC applied the USAID Passages social norms exploration (SNE) toolkit in June 2018 to identify the social norms and determinants of FP use at the community level in five high-fertility hot spot districts and sub-counties in Uganda. These districts were identified through a fertility hot spot mapping exercise conducted by APC. The districts were Kyegegwa (Hapuyo, Kyegegwa TC, and Kakabara sub-counties), Rubirizi (Katerera, Ryeru, and Katanda sub-counties), Agago (Kotimor, Omot, and Lamiyo sub-counties), Buyende (Bugaya, Kidera, and Buyende rural sub-counties), and Butaleja (Kachonga, Mazimasa, and Busaba sub-counties). The main subgroups of focus were teenage boys and girls ages 15–19 years, male and female youth ages 20–24 years, low-parity women ages 25–34 years, men ages 35–49, and other community influencers identified through influence mapping process (i.e., village health teams [VHTs], facility-level health workers, mothers).

The SNE tools were embedded into group discussions that focused on negative attitudes toward modern contraceptives, child marriage, teenage pregnancy, and high fertility. The “5 whys” tool was used in 50 group discussions, vignettes were used in 19, pocket charts in 21, and a problem tree in 14. We also applied my social network and influence mapping tools to identify key community influencers for each group discussion. The “5 whys” was the most utilized tool, largely because it is easily applicable and digs deeply to unearth highly entrenched root causes. APC also applied co-design principles learned from our application of experience-based-co design for FP at the community level, thereby enhancing the efficacy of the SNE approach. This multi-method approach allows for differentiated-dose implementation based on the realities on the ground, per district, from the beneficiary and stakeholder perspective, thus facilitating intervention co-design.

All data collected were qualitative, but they were quantified by way of code frequency after thematic analysis of content. The results showed that the main drivers of teenage pregnancy, child marriage, and high fertility were clustered under religious influence, poor parenting, poor-quality FP services, limited access at the community level, limited sexual and reproductive health information, factors around schooling, peer influence, economic factors, crime, and political factors.

Another key result of the exploration was the strong emergence of more negative social norms around modern FP methods, particularly around “quality of services.” Therefore, while negative norms around culture, religion, and tradition continue to hinder FP uptake and use, norms related to service quality have been established and are now deeply entrenched. These norms relate to the poor quality of FP services, but also long-standing myths and misinformation that also relate to the quality and mode of delivery of FP information at the community level.

The exploration brought to light the fact that low levels of male support for modern contraceptive use also has roots in poor quality of FP counseling. Men strongly noted that contraceptives make women weak so that they can't do household chores, and that bleeding disrupts their sexual life and causes them back pain. This points to poor-quality FP information and counseling for couples, especially on contraceptive side effects.

Poor socio-economic status and low levels of education also strongly influenced teenage pregnancy, child marriage, and the resultant high levels of fertility. These were further compounded by cultural beliefs among communities.

Religion was not highly ranked as a barrier to use but was identified as a key behavior that influenced FP use. Every person belongs to a religion or religio-cultural sect and has full trust in and allegiance to their religious leaders. Thus, communities suggested that religious leaders must be "actively involved" to positively influence behavior that supports modern contraceptive use. Religious leaders have further reach and more power than health workers.

Men across the five districts noted that they are not against contraceptive use, but that their wives or partners often start use without their consent. This suggests that the Emanzi community male engagement/educative model could be adapted within selected APC target districts, and that there is a need for more tailored male-focused information.

Few political leaders at the district and community levels are against modern contraceptives, but the impact of these few leaders is large. They are respected and have community following and trust; hence, any successful FP program should include them.

Cultural beliefs around the position of girls at the community level, the prestige that comes with large families, property sharing, or distribution based on the number of male children, and the fact that some cultures believe that the dowry of sisters must be used to pay bride prices were noted as key drivers of teenage pregnancy, child marriage, and high fertility. Therefore, a culturally sensitive approach is the most appropriate to increase FP use.

Very importantly, health workers and VHTs were noted as influencers of the FP use behaviors we targeted. These influencers are trusted by the community on health matters, including FP. Thus, APC will ensure that its implementation approach brings VHTs and health workers closer to the community to help demystify all misinformation. APC will ensure that its approach also brings services closer to the people, since access points were also noted as a barrier to contraceptive use.

A social, collaborative, multi-sectoral, and community-based approach is needed if the negative norms around FP are to be addressed to increase uptake and use of modern contraceptive methods. APC is therefore going to apply a community-driven collaborative improvement science approach to address the negative social norms around modern contraceptives.

## **Introduction**

### **About Advancing Partners & Communities**

Advancing Partners & Communities (APC) is a U.S. Agency for International Development (USAID)-funded global project led by John Snow, Inc. (JSI) and implemented by FHI 360. It supports and advances community programs focused on family planning (FP). According to the 2016 Uganda demographic and health survey, Uganda is a very young country, with 70 percent of the population younger than 25 years old. It has experienced a slight reduction in total fertility, from 6.7 to 5.4 children per women; an increase in modern contraception use, from 26 percent to 35 percent; a reduction in child mortality, from 38 to 22 deaths per 1,000 children; a reduction in under five mortality, from 90 to 64 deaths per 1,000 children; and a reduction in unmet need for FP, from 34 percent to 28 percent. In addition, 25 percent of adolescents ages 15–19 in Uganda have begun childbearing, and adolescent childbearing is more common in rural than urban areas (27 percent versus 19 percent).

APC is engaging in social norms exploration (SNE) to identify the social determinants of FP use and address barriers that start at the household level in five high-fertility hot spot districts in Uganda. This activity was designed in line with USAID/Uganda's Country Development Cooperation Strategy 2016–2021, authorized under development objective 2 of the strategy. Uganda has various religions, cultures, and traditions spread across its regions, and these may influence the use of modern contraceptives. Therefore, community level exploration to understand the barriers to contraceptive use and how they relate and vary across religion, culture, age, and geography is important if we are to design context-specific FP interventions to increase FP service delivery and quality. Therefore, APC conducted this exploration to understand and respond to deep-rooted norms, to be able to design interventions that will increase demand for and use of FP services.

### **Social norms exploration on contraceptive use**

Social norms represent a group's shared beliefs about what other people do, and their shared expectations about what they should and should not do. Social norms can help explain why a person performs or does not perform a behavior. In many instances, social norms are the accepted standards of behavior of social groups. Human beings need norms to guide and direct their behavior, to provide order and predictability in social relationships, and to make sense of and understand each other's actions. To this extent, there is always pressure on individuals and groups to conform to societal norms.

APC opted for a participatory approach for exploring social norms because it is in line with the activity description, which has a strong focus on community-led interventions, with a social lens. The Passages SNE toolkit (described below) was chosen as the basis for the exploration because it is inclusive, allows individuals and communities to be involved in project design, and caters to the uniqueness of the subpopulations we targeted. It also allows for differentiated implementation based on the realities on the ground, from the beneficiary and stakeholder perspective, thus facilitating learning from communities through intervention co-design. Thus, the focus was on norms that affect modern contraceptive use, and the factors that allow these norms and beliefs to remain entrenched.



## **Target behaviors**

The exploration was purposeful and targeted. The key behaviors that were explored were teenage pregnancy, child marriage, negative attitude toward modern contraceptives, and resulting high fertility. These behaviors were explored across age groups in all five districts. It should be noted that high fertility, teenage pregnancy, child marriage, and early school dropout are greatly influenced by low rates of modern contraceptive use. The exploration focused on the factors behind the negative beliefs that limit contraceptive use, and further explored the effects of this at the community level in each of the five districts.

## **Objectives of the Exploration**

The broad objective was to explore the social norms that affect FP demand and use in the five target districts. The specific objectives were to:

1. Identify the key influencers of FP use in the five target districts
2. Identify and categorize negative beliefs and norms toward FP use
3. Identify the drivers and social norms around high fertility, child marriage, and teenage pregnancy
4. Identify the norms around religion, culture/tradition, and schooling
5. Co-design interventions with the target populations and community influencers

## **Methods Used in the Exploration**

We used qualitative participatory methods to conduct the exploration. The application of the Passages SNE toolkit was re-enforced by qualitative inquiry by way of focus group discussions. All qualitative data were analyzed by thematic content, and responses were quantified so that the information was conveyed not only in words but also visually using Power BI and MS Excel.

## **Social Norms Exploration Tools Used**

### **1. My Social Networks**

This tool was used to collect information from each of the subpopulations, allowing us to profile the social reference groups for low contraceptive use, high teenage pregnancy, and fertility.

### **2. Influence Mapping Tool**

This tool was used to rank and visualize key influencers per subpopulation and gain a deeper understanding of who to target if we are to address issues around low use of modern contraceptives. This enabled APC to identify key influencers to involve in the improvement collaborative, which is a key approach in intervention design.

### **3. Vignettes**

APC teams developed short stories about teenage pregnancy, high fertility, and child marriage in the context of our subpopulations. This method allowed participants to think of the issues in the real world and think in community-centered ways about the problem of focus. We ensured that

the stories were culturally appropriate and acceptable for the community and subpopulations, by pre-testing them on non-participants in the same community. This facilitated deeper engagement of participants in exploring social norms that affect behavior, and the “fictitious reality” of the stories, without reference to anyone in their community. It helped the participants feel at ease and speak more freely. When they realized that the problem wasn’t only in their area, they easily opened up and gave vivid examples from their community, hence helping us identify negative social norms and practices around contraceptive use.

#### **4. Pocket Chart**

With this tool, participants were asked to vote on cards with negative beliefs and practices related to contraceptive use. This helped us ascertain whether these beliefs and practices occurred, and if so how frequently. This was one way of determining whether a practice or belief was a social norm or not, based on the votes per belief or practice discussed. The practices included child marriage, negative beliefs about FP, and myths/misconceptions, among others.

#### **5. Problem Tree**

This tool helped us understand the causes/determinants of high rates of teenage pregnancy, fertility, and child marriage, as well as their consequences. The problem tree helped both the target population and the influencers know what the effects of these behaviors would be if they continued.

#### **6. The 5 Whys**

Like the problem tree, this tool enabled participants to identify the root causes of the negative behaviors identified, but it dug deeper into the underlying causes than the tree did. We ranked the most critical and frequent causes by way of clustering and content analysis.

Four of the tools/methods above were supplemented and re-enforced by focus group discussions (Table 1). This brought out deep-rooted social aspects that had not been understood.

**Table 1: Focus group discussions, by SNE tool**

<b>SNE tool</b>	<b>Number of group discussions</b>
<b>5 whys</b>	50
<b>Pocket chart</b>	21
<b>Vignette</b>	19
<b>Problem tree</b>	14

### **Target groups**

The drivers of high teenage pregnancy and fertility rates vary according to demographic characteristics. The exploration looked at each community subpopulation by age and sex to understand the FP influencers, factors that affect FP use, and drivers for each group. The subpopulations were:

1. Boys and girls (teenagers) ages 14–19

2. Male and female youth ages 20–24
3. Low-parity women ages 25–34
4. Men ages 35–49
5. VHTs
6. Facility-level health workers

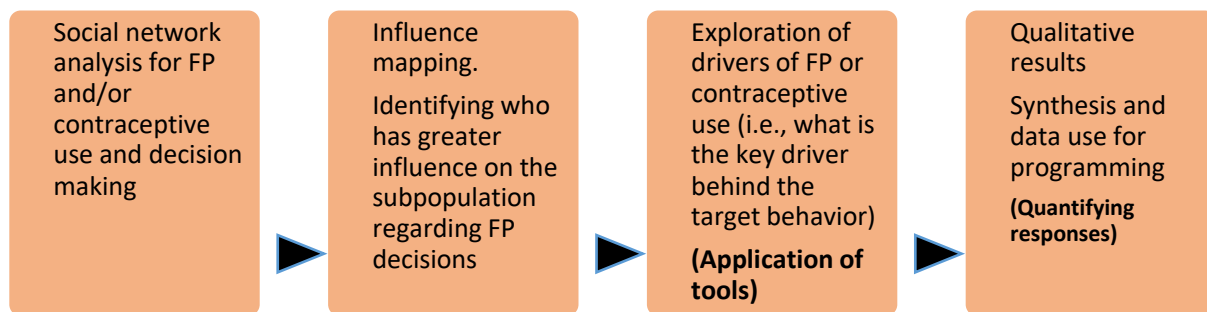
## Exploration Process

Fertility hot spot mapping had identified Agago, Buyende, Butaleja, Kyegegwa, and Rubirizi as districts with regionally high fertility and teenage pregnancy rates. Based on this, APC adapted the Passages SNE toolkit to deeply explore the social norms and drivers of contraceptive use in each of these districts.

For each subpopulation and by way of co-design, APC sought suggestions from the group and its influencers on what can be done to reduce fertility, teenage pregnancy, and child marriage and increase contraceptive use.

For each subpopulation, APC followed the process indicated in Figure 1.

**Figure 1: The SNE process**

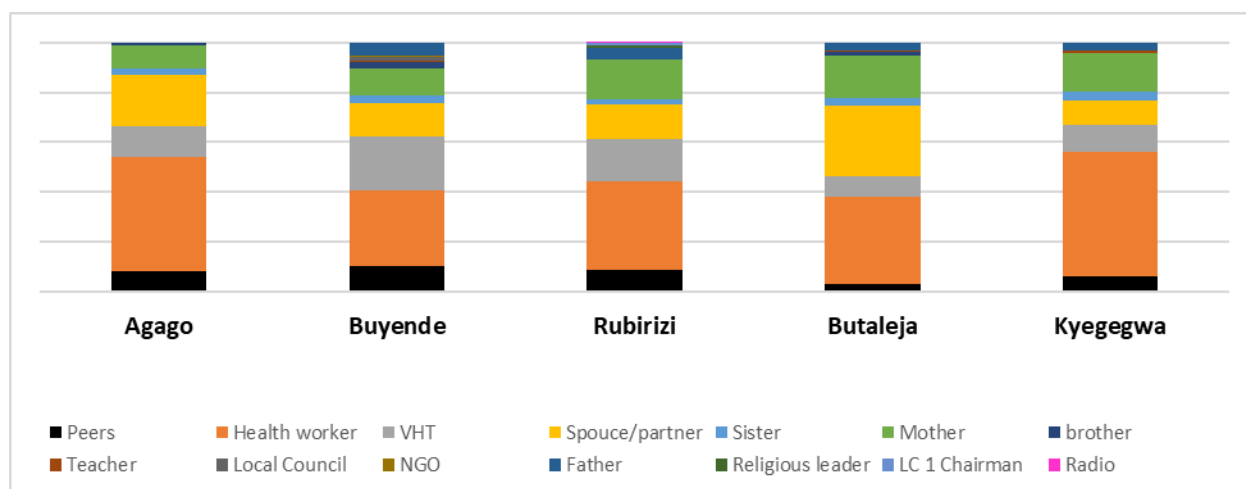


## Key Findings

### Social network analysis and influence mapping

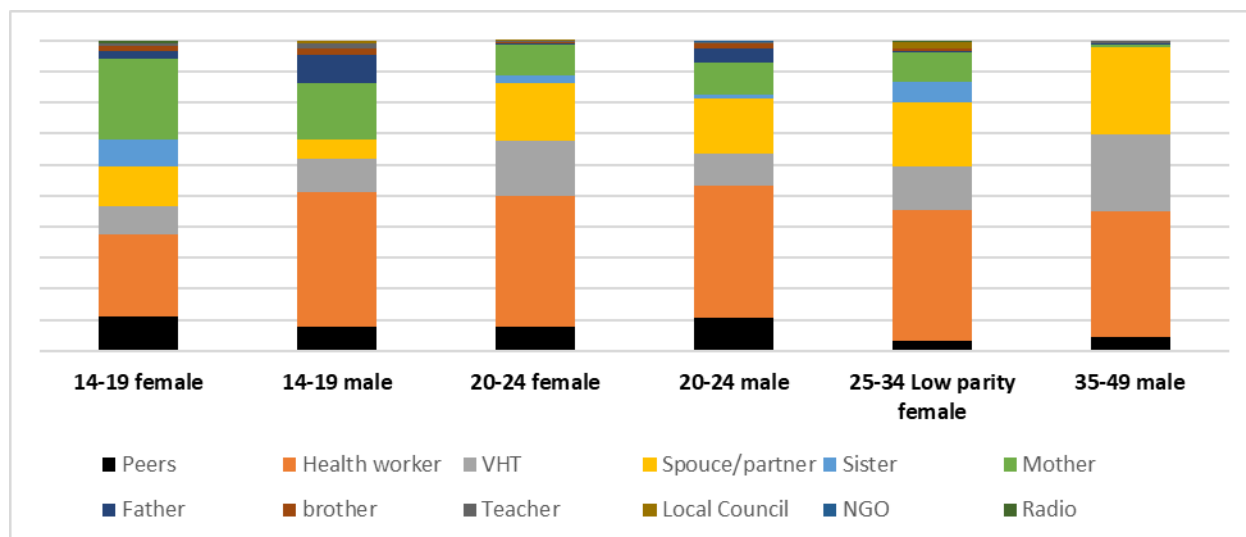
Results from the social network analysis and influence mapping identified the key influencers for FP use to be health workers, VHTs, mothers, spouses/partners, peers, siblings, Local Councils, radio, religious leaders, and teachers in all five districts. However, there was variation in the level of influence per influencer across districts. For example, spouses played a bigger part in influencing FP use in Butaleja and Agago than in Kyegegwa, Buyende, and Rubirizi. Radio information was ranked as the lowest influencer of FP decision making, as shown in Figure 2.

**Figure 2: Influencers of FP use, by district**



Further, analysis of influence mapping indicated variation in influence according to age group. For example, there was less peer influence among men ages 35–49 years than among younger men. Teenagers preferred intimating to their mothers and health workers than to other categories of influencers, and low-parity women ages 25–34 were influenced more by health workers and their partners/spouses than were much younger women. This points to a need to use a dosing approach during implementation of interventions. It was also evident that health workers and VHTs remain a key influencer of FP decision making across all age groups, as illustrated in Figure 3.

**Figure 3: Influencers of FP use, by age group**



## Results from focus group discussions (vignettes, 5 whys, problem tree, pocket chart)

### Categorizing negative beliefs toward contraceptive use

Based on the low use of FP methods, APC made an inquiry into the most common negative beliefs toward FP use. Many beliefs were mentioned, and we categorized them by theme (i.e., religious beliefs, promiscuity, cultural beliefs, side effects/poor quality of services, myths/misconceptions). Based on responses from participants across all age groups and districts, by way of categorical ranking, the beliefs that were turning into norms (what should or should not be done, accepted, and believed as right by communities) were largely related to myths/misconceptions, side effects/quality, cultural beliefs, extra-marital affairs, and religious beliefs (Figure 4).

**Figure 4: Categorization of negative norms and beliefs on contraceptive use**



Religion was identified as a key driver of negative norms around FP, and several beliefs/norms are now built around religion and religio-cultural sects. This was noted by some participants of the SNE process, as noted below. It is also evident from the following quotes that religion negatively affects FP use in high-fertility hot spots, across age groups and districts:

*“In church, it’s believed that family planning is a devilish practice, it’s satanic, and it is killing children.” (Male participant age 35–49, Agago)*

*“Personally, I am a Catholic and our reverend Father says that the use of condom has brought promiscuity in our community; he is so against it.” (Male participant age 20–24, Rubirizi)*

*“Catholics only preach withdrawal, they say the rest of the methods are not natural and are against the bible. The priest usually tells us if you use a condom, its fluids will later kill you.” (Male participant age 20–24, Kyegegwa)*

*“Bisaka is our God and he discourages us from using FP. He told us that it is a white man’s initiative to reduce the population of Africa.” (Female participant age 15–19, Kyegegwa)*

Men were also identified as being unsupportive of their partners using FP in most cases. They held deep misconceptions around the side effects and believed that FP causes women to be dry, that it causes cancer, and that their wives will have extra-marital affairs (and these beliefs have been known for decades). However, the exploration brought to light the fact that these beliefs were linked to the quality of the information men had and to the fact that most who had used FP before saw their wives experiencing negative side effects, without management. Therefore, addressing the issue of unsupportive husbands is not only about sensitizing men, but also about making sure that the information they receive is of high quality and is comprehensive, including adverse side effects and how they are managed. This could build their resilience to cope, as evidenced by the following quotes:

*“Most men in this community believe that when their women join family planning, they get dry so women end up in fear of getting dry and their husbands leave them for other women.” (Male participant age 35–49, Rubirizi)*

*“You know the problem is when we let our wives use FP, they start cheating, they know they will not conceive.” (Male participant age 35–49, Kyegegwa)*

*“Family planning makes women to behave like young girls and they go out to have fun.” (Male participant age 20–24, Agago)*

*“Before the woman uses the family planning, she has a lot of water and is sweet but when she uses any method, her water reduces and when you are having sex you even feel pain.” (Male participant age 35–49, Rubirizi)*

*“When the doctors put in you the IUD [intrauterine device], it infects the womb and it brings cancer and the truth be to it, the injection too brings dryness, which we the men don’t want.” (Male participant age 20–24, Kyegegwa)*

Culture was the other factor around which negative norms of FP had been built and entrenched, as one of the participants noted:

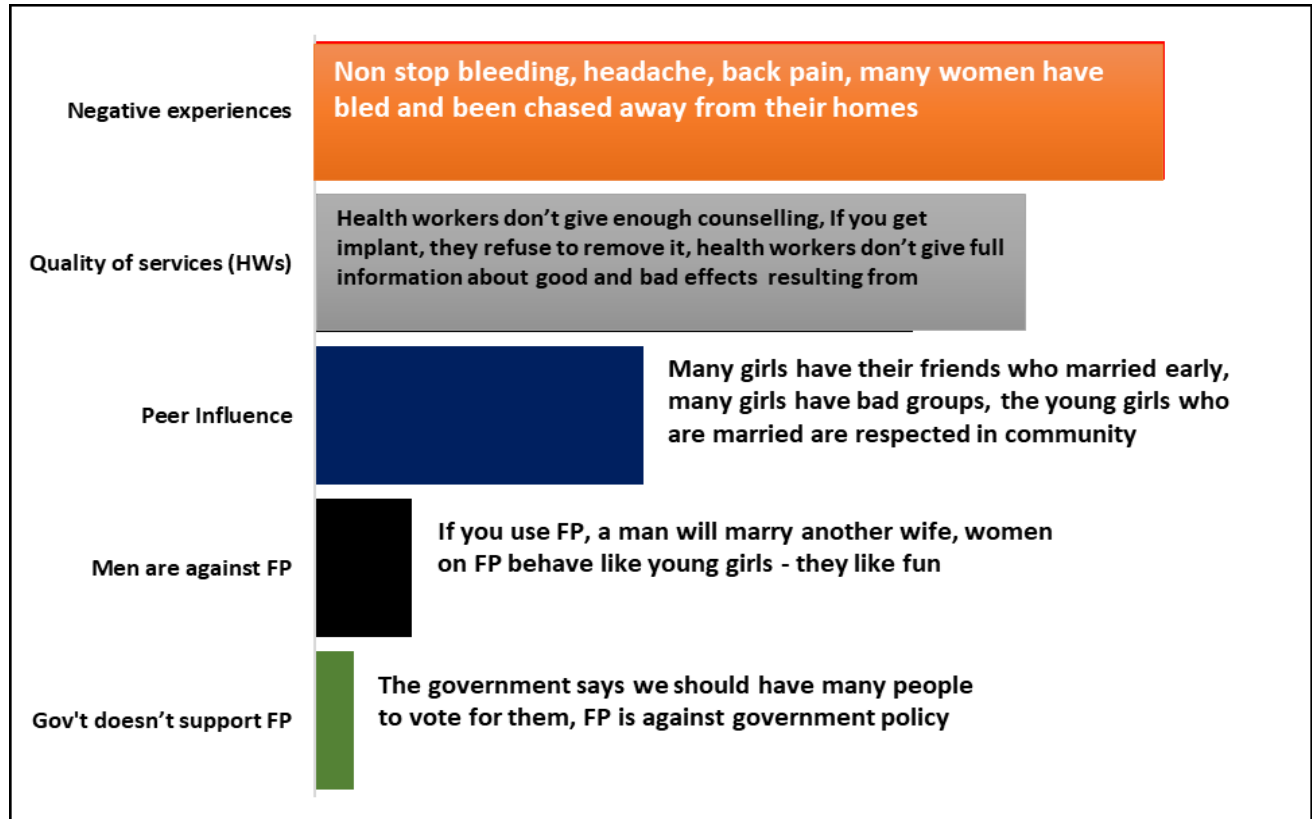
*“The culture here says that if I want to marry and I have no dowry, they will force my younger sister to get married early since there is no money so that the elder brother can get married.” (Male participant age 20-24, Agago)*

Therefore, in this region, such a cultural norm (which is generally accepted as a standard) has caused too many child marriages, thereby compounding the problem of high rates of teenage pregnancy and fertility in the area.

### **Factors that facilitate the entrenchment of negative beliefs and norms about FP**

It should be noted that the beliefs mentioned above are not new. It’s just that now they have turned into community norms. In other words, they are universally accepted as facts, and the community members have to conform to them. If they do not conform, then their sense of belonging to that community can be affected. We therefore sought to find the reasons why these beliefs have remained entrenched for so long, despite several interventions to change community perceptions. Most responses were related to negative experiences and poor-quality services. Other reasons were peer influence, limited male engagement or support, and bad government policy. Because many of the norms are related to side effects and quality of services, interventions designed MUST address these factors, as well as male involvement, if FP uptake is to increase. Figure 5 shows a thematic categorization of factors facilitating entrenchment of negative beliefs and norms toward FP use.

**Figure 5:** Why negative beliefs/norms around FP are entrenched



It was noted in some districts, such as Buyende, that the negative beliefs are entrenched because political leaders are against FP use. The leaders encourage people to have many children so that they will have many voters in the future. This has led to intra-community and inter-tribal competition to have more children, so as to dominate political power. One of the respondents noted:

*“Our leaders encourage people to produce many children just because they know that the more people produce, the more votes they get. Therefore, they go ahead and advocate to produce many children so that in future they are in position to get those votes.”*  
(Female participant age 35–49, Buyende)

Negative experiences also contributed to these norms and beliefs remaining entrenched, as there were vivid examples of people who suffered while using FP, were not given adequate counseling on side effects, or were not treated. The experiences had been talked about in the community, leading them to become accepted norms. Some of the experiences are described below, in the words of participants:

*“For example, my wife used FP, she would spend three days in periods. But when she started FP, she now spends over a week and worse still in that month, she can go in her periods twice.”* (Male participant age 20–24, Rubirizi)

*“My sister was injected with FP method but from July 2017, she is still bleeding up to now, whenever I tell my husband about FP, he reminds me of my sister’s ordeal.”*  
(Female participant age 20–24, Butaleja)

*“I have a personal experience because I used to go in menstruation periods, once in month but after using FP, I now go in menstruation thrice in a month and my friends are not as patient as me.”* (Female participant age 25–34, Butaleja)

*“I used FP and I lost a lot of weight and became a laughing stalk in the village, I was called an HIV patient and was consistently in hospital. I decided to stop using it and conceived yet I had a 9 months old baby.”* (Female participant age 20–24, Kyegegwa)

From the above quotes, it is not surprising that the new social norms around FP are linked to quality of services. Thus, interventions to transform these negative norms on FP must address the service quality concerns.

### **Common social norms per district.**

The pocket chart tool enabled the exploration team to identify the most common norms in each of the five districts. This tool allowed target populations and influencers to categorize practices as either beliefs that a few people have or as norms that are accepted by the community. This enabled the exploration team to understand the common norms around FP in the target districts as reflected in Figure 6 below.



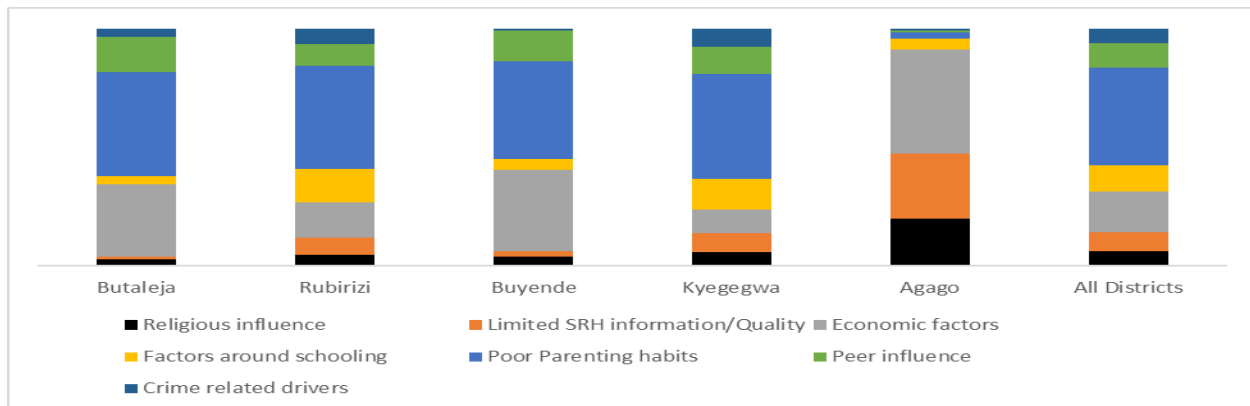
**Figure 6: Examples of norms in the five districts**

<b><u>Agago District:</u></b>	<b><u>Butaleja District:</u></b>	<b><u>Kyegegwa District:</u></b>
1 - Women produce lame or deformed children because they used family planning	1 - Women who use FP get uterus damage when the eggs burn in the womb	1 - Family planning methods cause cancer and destroy a woman's uterus
2 - Families with many children especially male are respected and the wife is secure in the home	2 - Women using FP will start sleeping with other men since they will not get pregnant	2 - Among Bisaka followers (religio-cultural), if you use FP, you commit murder
3 - Women who are on family planning sleep with other men and can bring AIDS to the man	3 - Women with few children are easily divorced and the man stays with the one with more children	3 - When confessing murder due to FP, it is expensive to seek redemption
4 - Blessings come to a home when the boy uses dowry of his sister to marry	4 - Family planning is a deal of Europeans and our government to reduce population	4 - Women must produce as much as they can to outcompete other clans
<b><u>Rubirizi District:</u></b>	<b><u>Buyende District:</u></b>	5 - The greatest purpose on earth is to produce and multiply
1 - When women used FP early, in future, she will produce few children because her eggs will have reduced	1- FP damages the uterus and lowers sexual appetite	6 - Herbalists who tie the womb supernaturally until you are ready to conceive are better than using modern FP methods
2 - Contraceptives cause cervical cancer	2 - Women who use FP cannot deliver safely, they must be cut and will have only 3 or 4 children maximum	7 - Family planning was introduced to reduce the population of Africans
3 - When you use family planning, the man - will leave you and marry another woman because you will be dry	3 - Women on FP produce premature children and get barren	8 - There is no need of taking a girl to school yet she will get married and leave you
4 - Family planning makes women weak and sickly, they cannot dig or do household work	4 - Many women on FP over bleed and need more blood or die if not treated well	<b>Norms around negative experiences, side effects and mis-information were the most pronounced across all the five target districts.</b>

### **Drivers of teenage pregnancy, by District**

The exploration also unearthed the deep-rooted norms and drivers of teenage pregnancy in the five target districts. Figure 7 illustrates categorized responses per district. The themes that emerged were religious influence, poor parenting, limited sexual and reproductive health (SRH) information at the village level, factors around schooling, peer influence, economic factors, and crime-related drivers (i.e., rape, defilement, child marriage). Therefore, APC's interventions should be multi-dimensional if we are to contribute to a reduction in teenage pregnancy. Addressing a single driver will not solve the problem decisively.

**Figure 7: Drivers of teenage pregnancy; by District**



Discussions with participants reinforced the findings that poor parenting, economic factors, peer influence, and factors around schooling were most responsible for accelerating teenage pregnancy:

*“Even we parents have become too modern. We no longer have time of sitting and talking to our families. A parent wakes up in the morning and goes to the bar and return at midnight and he doesn’t have time to know how the son has been or what time the daughter entered the house.” (Influencer, Rubirizi)*

*“Parents don’t care; if parents know where I am going, when I return, they should ask me where I am coming from. If I know my parents look for me, then I do not go into these things.” (Female participant age 15–19, Rubirizi)*

*We parents are somehow to blame because we have not given sex education to our children and yet they too have demanding bodies, which led them in sexual intercourse and end up getting pregnant. (Influencer, Kyegegwa)*

*“The pastor said that I want those people who are going for family planning God to burn their wombs such that they suffer from cancer because the box that carries the drugs had a word SA which means self-abortion. There you are murdering, which means that a curse to God, but everyone who is going for family planning, I want that medicine to start burning their wombs and you suffer.” (Female participant age 15–19, Buyende)*

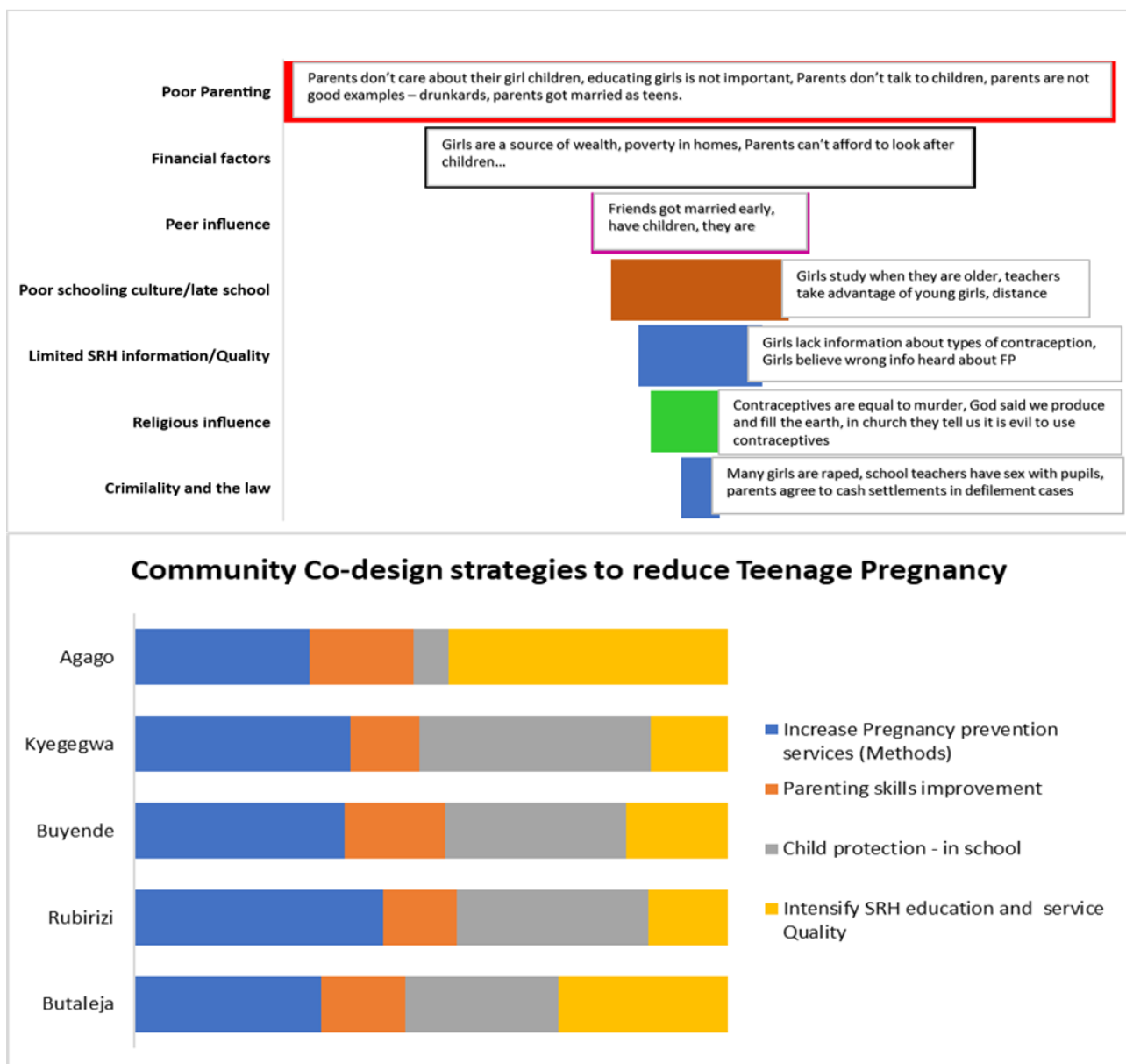
*“My girlfriend overbled while using FP so we stopped using it anyway, it was even a mistake because Muslims don’t use family planning, we used it because we were not ready to have children.” (Male participant age 15–19, Butaleja)*

A closer look at Figure 7 reveals that in the western districts of Rubirizi and Kyegegwa, teenage pregnancy was not largely driven by economic/financial factors, as was the case in Agago, Buyende, and Butaleja. Further still, parenting did not emerge as a top driver in Agago, unlike all other districts. Hence, APC will adopt a differentiated implementation approach for interventions following the exploration process.

## Deep rooted drivers by category, and strategies to reduce teenage pregnancy from the intervention co-design process

APC adapted user-centered co-design principles from the experience-based co-design (EBCD) methodology. A deeper hierarchical analysis ranked poor parenting, financial/economic factors, peer influence, and negative factors around schooling as top drivers of teenage pregnancy. However, other factors around criminality, quality, and religious influence were noted and can't be overlooked (Figure 8). Community co-design strategies that emerged for reducing teenage pregnancy are described in Figure 8 below.

**Figure 8: Drivers by category and co-design strategies to reduce teenage pregnancy**

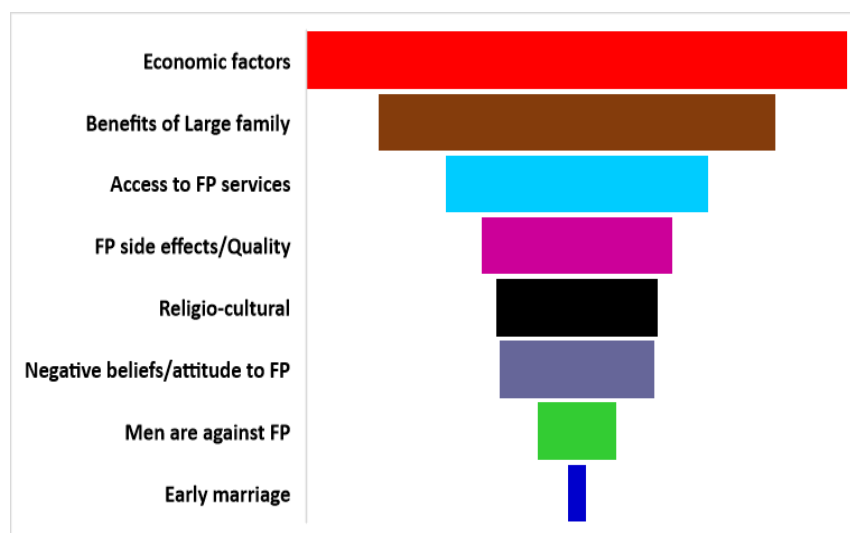


The exploration also delved into the drivers of high fertility. After content analysis and code frequency, results showed economic factors, benefits of a large family (related to community customs), limited access to FP services, poor quality of FP services, and religio-cultural factors as the top five drivers of high fertility overall (Figure 9) and by district (Figure 10).

**Figure 9: Drivers of high fertility**

Overall, most people said that the biggest drivers of high fertility were related to Economic/financial factors, perceived benefits of large family, accessibility to services, quality of FP services, religio-cultural factors, negative beliefs about FP, male resistance and lastly early marriage.

Most definitely, given the multi-sectoral and multi-dimensional nature of

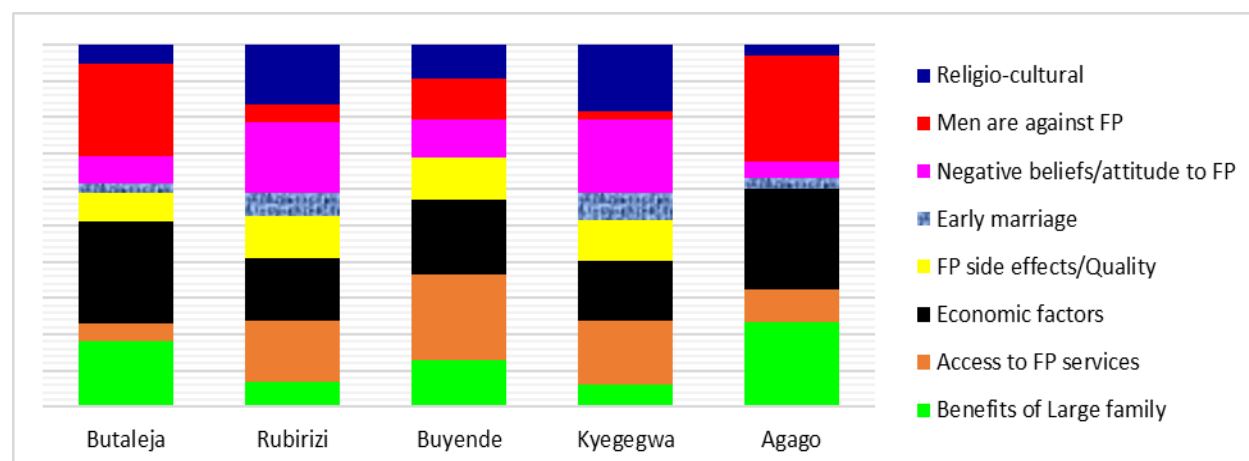


these drivers, the solutions must also be multi-sectoral and integrated.

No single solution can address all these but rather collaborative efforts of all stakeholders both in health and non-health sectors.

However, different districts are affected at different levels by the drivers identified above. For example, male resistance is most pronounced in Butajela and Agago districts while negative beliefs and attitudes are more pronounced in Rubirizi and Kyegegwa. This therefore means that we should design interventions which are multi-sectoral, with more focus on the bigger drivers. This is illustrated in figure 10 below.

**Figure 10: Drivers of high fertility, by district**



The following are representative quotes related to drivers of high fertility, as stated by target populations across the 5 fertility hotspot districts:

*“...women always go to clinics that have health workers that cannot administer these family planning methods effectively, health workers are not trained well and the other being we men lack proper sensitization about family planning methods so we end up being rough on our wives when family planning affects them.” (Male participant age 20–24, Buyende)*

*“Like us women, when using FP, we come to the time of period, we overbleed, that is why end up fearing to use it. FP makes you very small or very fat. You find yourself in periods for long, so the men end up telling you to stop FP or he gets other wives.” (Female participant age 24–35 Rubirizi)*

*“Me, in my family, they say if we did not kill you, then why you would want to kill the children God has given you all in the name of family planning?” (Female participant age 20–24, Kyegegwa)*

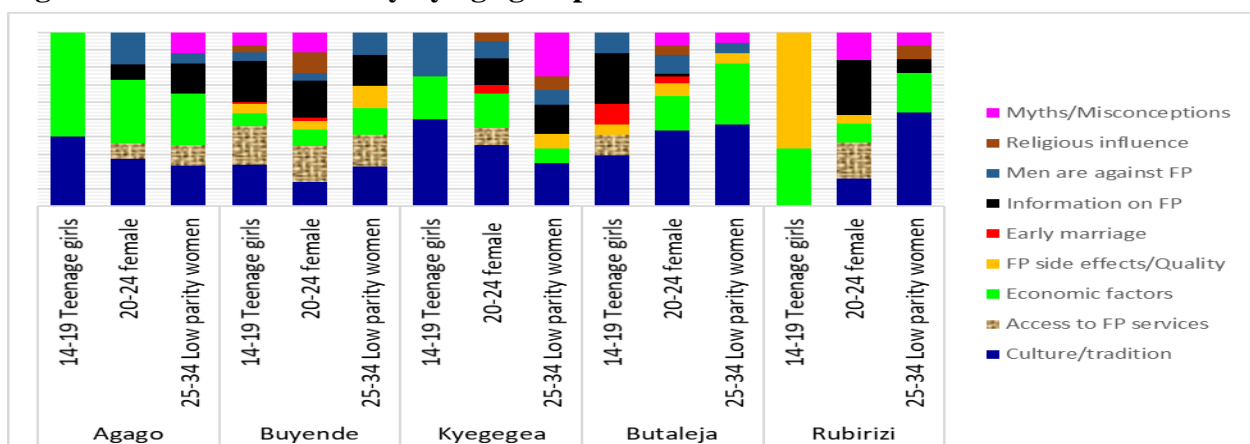
*“After starting family planning, sex feelings go away and this has damaged many relationships in our community. You are sleeping like a man as if you are sleeping with a fellow man.” (Female participant age 24–29, Rubirizi)*

*“I am a Muslim, our religion preaches against it, they say it’s a murder.” (Male participant age 20–24, Kyegegwa)*

Based on the above results and quotes, the drivers of high fertility arise from multi-dimensional beliefs and practices. It is these beliefs and practices that have now become social standards against which people see others as either conforming or not conforming. Hence, these norms influence FP use at individual, household, family, and community levels. Conforming results in high fertility.

Furthermore, the exploration showed that there are variations in drivers based on age. For example, according to figure 11 below, among the adolescents in Agago fertility is driven more by economic factors and culture while in Rubirizi, the fear of FP side effects, poor quality and economic factors account for the high fertility. Therefore, even among various age groups, the intervention or dosage must be differentiated which will save resources.

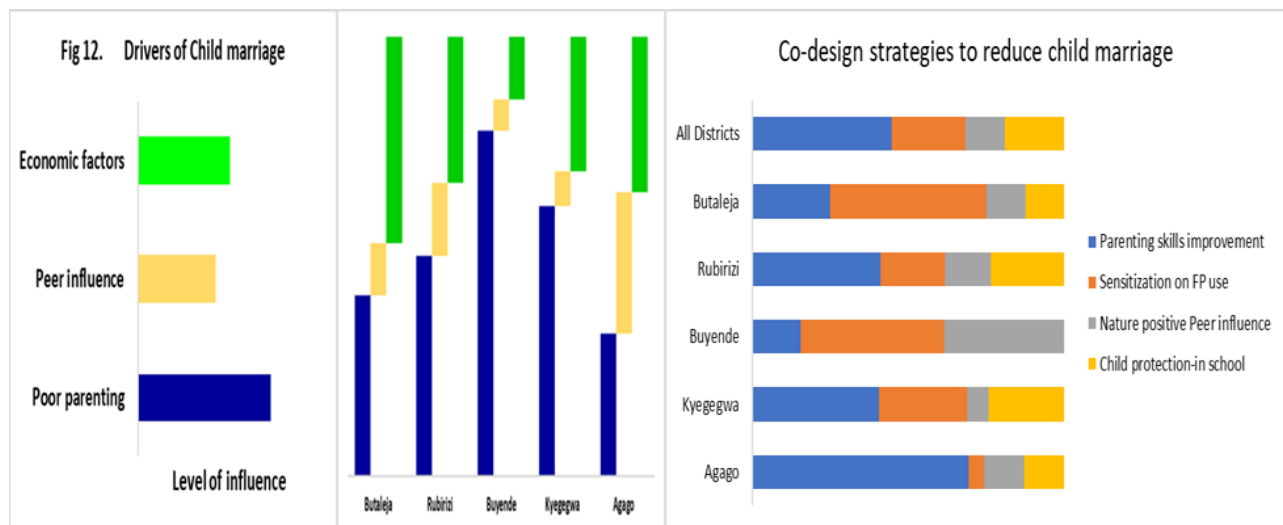
**Figure 11: Drivers of fertility by age group**



## Drivers of child marriage and co-design strategies to reduce the practice

Poor parenting, economic factors, and negative peer influence were identified as drivers of child marriage from the results of the pocket chart and 5 whys tools. It should be noted that many parents were illiterate and most likely didn't value education, were married off at a young age, and were economically incapacitated. This was compounded by the fact that in most rural schools, child protection was poor, especially for girls. Girls are very vulnerable. Figure 12 shows the drivers of child marriage and co-design strategies proposed to reduce the practice.

**Figure 12: Drivers of child marriage and co-design strategies to reduce the practice**



From the focus group discussions, it was evident that parenting was a huge driver of child marriage and this was the view by both the teenagers interviewed the women 25-34 who were part of the exploration exercise. Below is what some of them said:

*“Our parents do not give enough things to use like pads, knickers, soap, and when a man offers to give you those things, they ask for sex in return.” (Female participant age 15–19, Butaleja)*

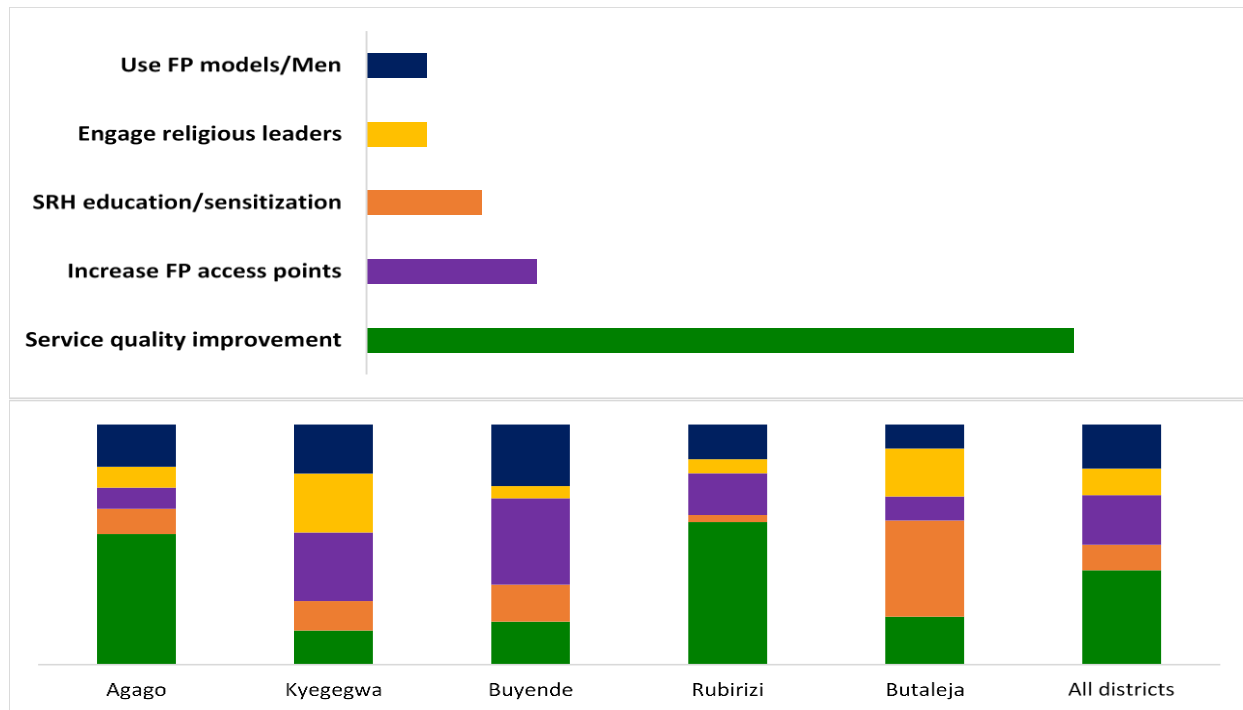
*“Parents don't care; if parents know where I am going, when I return, they should ask me where I am coming from. If I know my parents look for me, then I do not go into these things.” (Female participant age 15–19, Rubirizi)*

*“We parents are somehow to blame because we have not given sex education to our children and yet they too have demanding bodies, which lead them in sexual intercourse and end up getting pregnant.” (Influencer, Kyegegwa)*

## Community co-design strategies to increase contraceptive use

By way of co-design, together with the target communities and influencers, the main strategies that emerged for increasing FP use were involving men, actively engaging religious leaders, improving FP service quality, implementing more FP sensitization, and increasing access points (Figure 13).

**Figure 13: Co-design strategies to increase contraceptive use**



The most pronounced remedy to high fertility was increase access points at community level, and as much as possible take long term methods to the community as well. Male involvement although not noted as a huge contributor to increased FP access, it was noted that men should be involved because they hold power in homes and can negatively influence their wives to leave FP. Below is what some of them said;

*“Men should be educated as well on FP, not only women. In most cases, when such programs happen, only women are called upon, yet they need us the men when making such decision since we are both involved in this.” (Male participant age 35–49, Agago)*

*“The men should be put aside and educated on how useful FP is, sometimes we don’t go to check because we have run away from home and gone to a clinic to put FP without our husbands, knowing they don’t agree with it. (Female participant age 24–35, Kyegegwa)*

## Lessons Learned from the Exploration

- Although we thought that the most negative norms driving high fertility and teenage pregnancy were around cultural and religious factors, the exploration indicated that the drivers and now **“emerging social norms”** are largely related to quality of FP services. Most myths and misconceptions are also linked to the quality of SRH information and FP service quality, and most reasons for believing that FP is dangerous among women are around poor counseling. Therefore, quality improvement in FP services is a vital ingredient for increasing uptake. As a result, APC will continue to scale up the FP quality improvement innovations tested and confirmed at the Center of Excellence in Busia and Oyam and will continue to support RHITES to apply improvement science for community-based FP. Negative social norms around religion and culture are prevalent, but they cannot be addressed in isolation because they are directly linked to gaps in service quality.
- Although religion was among the least influential factor affecting FP use, it has a great positive impact on community behavior toward FP. Hence, it ranked low as a barrier but has the potential to drastically influence behavior and increase contraceptive use at the community level. This, according to the community, is because religious leaders are trusted agents of God, and each community member believes in one of the dominant religions (e.g., Catholic, Seventh Day Adventist, Protestant/Anglican, Muslim, Religio-Cultural Sect like Bisaka and Mungu Mwema [Rubirizi]). Participants in all subpopulations in all districts noted that religious institutions should do more to encourage FP use because most of the people respect, listen to, and do as religious leaders guide them to do. Thus, interventions that seek to increase FP use should use these channels.
- Men were not identified in the influence mapping process as key players that young people talk to about FP. However, the co-design process identified them as having power to influence FP use at the community level because they have power to drive decisions at the household level. Therefore, it is essential that men are brought on board. Discussions with men revealed that their biggest fears were around side effects, misconceptions, and limited SRH information.
- Poor Parenting emerged as a strong driver of teenage pregnancy and child marriage. However, parenting is also influenced by other drivers (i.e., social-economic status of the household, cultural beliefs). These too must be addressed squarely.
- APC applied EBCD principles in collaborative co-design, which revealed that religious leaders, school teachers, cultural leaders, and local political leaders are ready and willing to support contraceptive use and pregnancy prevention interventions locally but need support. Therefore, they are going to be key players in the collaborative improvement charter, because they noted that they can play a big role but are often neglected or overseen. This will bring a social accountability element to APC’s FP program, increasing ownership since the intervention will be community-led. We also anticipate that this innovative co-design process has the potential of increase intervention



effectiveness since it facilitates inclusion, innovation, local ownership, learning from data and ongoing collaborative improvement.

- From the drivers and strategies proposed by communities, fertility cannot be reduced by contraceptives alone, there is need for other sectors and actors to come in and do sensitization, provide guidance and counselling among others to young adolescents, men and women of low parity. This approach will enable APC to get more stakeholders and champions of pregnancy prevention especially those against contraception but are willing to use information to sensitize the community.

## **Conclusion**

The dominant negative social norms are around quality of FP services, particularly side-effect counseling and management and poor-quality information about FP that allows myths to spread.

A collaborative improvement science model is more appropriate for ensuring that interventions are successful because it is community-driven, allows for innovation, is data-driven, fosters accountability from the district to community level, is context-specific, and brings multiple stakeholders together to address a common objective or problem.

Religion, culture, schooling, and male partners were identified as having the potential to accelerate behavioral change, largely because of power, influence, respect, and trust. Therefore, FP and pregnancy prevention messaging and services need to be designed with these four areas in mind.

The SNE process is a good way of unearthing and categorizing deep-rooted negative norms around modern contraceptive use. FP programs should innovatively apply it within the framework of EBCD for better results. Although we didn't apply EBCD as a full package, applying a few EBCD principles made our approach more rich and effective.

APC is going to move quickly to co-design pregnancy prevention and modern contraceptive use interventions with religious leaders, teachers, cultural leaders, political leaders, players from the health and non-health sectors, and men as influencers to increase FP use at the community level.

From our exploration, it is clear that with this multi-dimensional mix in drivers and negative norms toward FP, a socially oriented, multi-sectoral, community-driven and inclusive approach is needed to increase FP use.

## Recommendations

- Midwives and VHTs must address quality issues squarely and continuously provide accurate information to communities if myths, misconceptions, and misinformation are to be reduced and, over time, eliminated at the community level. This should follow a community-based approach in which health workers conduct dialogues specific to negative norms. Management of side effects should be given priority during any contraceptive-use encounters with clients and community sensitization. APC will use **“reproductive health service cafes”** to increase information dissemination at the community level, given that inadequate SRH information was noted as a key gap and driver. This will mostly target the illiterate and out-of-school youth.
- A strong economic base for the household can overpower culture and shield young girls from being married off early or being compromised. Child marriage and teenage pregnancy cannot be addressed without addressing the household and community social-economic drivers. Therefore, a multi-dimensional implementation approach in which FP interventions work hand in hand with other sectors is key for reducing teenage pregnancy and child marriage.
- Religious and other faith-based leaders should be engaged more and trained or sensitized to ensure that they have accurate information about modern contraceptives. This is when their platforms will be ably used to influence uptake and use. These leaders have power to influence community behavior because almost every person belongs to a religion or cultural group, and all power is in the leaders.
- Political leaders need to be brought on board and encouraged to talk about FP use in the context of community and household development. Political leaders have many community followers who trust in their word; hence, FP programs should engage them from the district to community leadership level. This has the potential of increasing funds allocated for FP in support of the FP costed implementation plan.
- FP programs should focus on improving parenting skills at the community level. Some parents were never parented well themselves, and the cycle may continue if they aren't properly orientated on parenting.
- Schools should be linked to FP programs, as child protection in schools was noted as a driver of teenage pregnancy. Some girls get pregnant from relations with teachers, and some teachers have relations with other teachers, even though the teachers are not married yet and are expected to be role models. Teachers have the platform to empower and influence both students and parents if they are equipped and actively engaged. Thus, engaging teachers would be vital for preventing pregnancy among teenagers and reducing child marriage.
- Male involvement and sensitization should be increased. APC will adapt the Emanzi intervention to the areas that need community male engagement. However, we will go beyond just sensitization to introduce a knowledge-sharing and referral network among the trained Emanzi at the community level. Because APC can't train all community men, the few that are trained can have a radial effect by telling other men about FP.

- A localized communication strategy about FP is needed to speak to what people have experienced and what they now believe in. Otherwise, mass media communication strategies may not provide the information that is needed to potentially change behavior around FP. This is because context matters in information dissemination, and information should be locally driven and delivered in ways that the intended user (i.e., poorest of the poor) can afford (i.e., read or hear). For example, although it is very critical in FP communication, radio was not identified as an influential source of FP information.
- Any stakeholder using the Passages social norm tool kit should add the element of co-design to make it richer and more useful to us all. It allows participants to suggest solutions to their own problems as perceived by themselves, which increases chances of success in a non-prescriptive manner. It is very particularly useful if you co-design the response intervention with influencers alone on one hand, and the target populations on the other and later create space for interface to agree on a common intervention.