

## ORIGINAL RESEARCH ARTICLE

# Community and Provider Perspectives on Addressing Unmet Need for Contraception: Key Findings from a Formative Phase Research in Kenya, South Africa and Zambia (2015-2016)

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## Abstract

Unmet need for contraception remains a challenge especially in low and middle-income countries. Community participation or the “active involvement of affected populations in all stages of decision-making and implementation of policies, programs, and services” is a precondition for attaining the highest standard of health. Participation as a key component of rights and quality of care frameworks could increase met needs. However, it has been inadequately addressed in contraceptive programs. A qualitative, exploratory methodology that included focus group discussions and in-depth interviews with community members, healthcare providers, and other stakeholders were conducted to identify domains or key thematic areas of action through which stakeholders could be engaged. The study conducted in Kenya, South Africa, and Zambia explored knowledge and use of contraceptives, barriers and enablers to access, quality of care, and participatory practices. Thematic analysis was used, facilitated by NVivo (version 10 QSR International) with a single master codebook. Comparing the thematic areas that emerged from the county data, four domains were selected: quality of care, informed decision-making, acceptability, and accountability. These domains informed the theory of change of a participatory programme aiming to meet unmet needs. Identifying possible generalizable domains establishes measurable and comparable intermediate outcomes for participatory programs despite diverse African contexts. (*Afr J Reprod Health* 2019; 23[3]: 106-119).

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**Keywords:** Community participation, unmet need, family planning

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## Résumé

Les besoins non satisfaits en matière de contraception restent un problème, en particulier dans les pays à revenu faible et intermédiaire. La participation communautaire ou la "participation active des populations touchées à toutes les étapes de la prise de décision et de la mise en œuvre des politiques, des programmes et des services" est une condition préalable pour atteindre le niveau de santé optimal. La participation en tant qu'élément clé des cadres relatifs aux droits et à la qualité des soins peuvent augmenter les besoins satisfaits. Toutefois ceci n'a été suffisamment abordé dans des programmes contraceptifs. Une méthodologie exploratoire qualitative comprenant des discussions de groupe et des entretiens approfondis avec des membres de la communauté, des prestataires de soins de santé et d'autres parties prenantes a été menée pour identifier des domaines ou des domaines thématiques clés d'action à travers lesquels les parties prenantes pouvaient être engagés. L'étude menée au Kenya, en Afrique du Sud et en Zambie a exploré la connaissance et l'utilisation des contraceptifs, les obstacles et les facilitateurs d'accès, la qualité des soins et les pratiques participatives. Une analyse thématique a été utilisée, facilitée par NVivo (version 10 QSR International) avec un seul livre de codes maître. En se basant sur les données des comtés, quatre domaines ont été sélectionnés:

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qualité des soins, prise de décision en connaissance de cause, acceptabilité et responsabilité. Ces domaines ont éclairé la théorie du changement d'un programme participatif visant à répondre à des besoins non satisfaits. Identifier les domaines généralisables possibles établit des résultats intermédiaires mesurables et comparables pour les programmes participatifs malgré la diversité des contextes africains. (*Afr J Reprod Health* 2019; 23[3]: 106-119).

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**Mots-clés:** Participation, besoin non satisfait, planification familiale, contraception

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## Introduction

Unmet need for contraception remains high in many settings, especially among the most vulnerable in society including adolescents, the poor, those living in rural areas and urban slums, and internally displaced people<sup>1</sup>. In 2017, an estimated 214 million women in developing countries had an unmet need for contraception<sup>1</sup>; that is, they were at risk of becoming pregnant when they did not wish to conceive yet were not using a modern method to prevent pregnancy<sup>2</sup>. The impact of unmet need is broad, spanning social, economic and health outcomes<sup>1</sup>. Meeting unmet need for modern contraception could potentially result in an estimated 76,000 fewer maternal deaths each year and reduce new born deaths per year from 1.8 million to 655,000<sup>1</sup>. Women and their partners who can have a child but are not using contraceptives or are using a traditional method have higher chances of having an unintended pregnancy that puts them at higher risk of having an unsafe abortion<sup>1</sup>.

Community participation, defined by the World Health Organization (WHO)<sup>3</sup> as the "active involvement of affected populations in all stages of decision-making and implementation of policies, programs, and services" has been recognized as a precondition for sustainable development and achieving the highest attainable standard of health<sup>4</sup>. In the provision of contraceptive information and services, participation is a key component of quality of care (QoC)<sup>5</sup> and human rights (HR) frameworks<sup>3,5,6</sup>. Increasing community participation is also in line with the Global Strategy for Women's, Children's and Adolescents' Health 2016-2030<sup>7</sup>, which strives for a world in which every woman, every child, and every adolescent are able to *Survive, Thrive* and *Transform*. Despite its importance, community participation has been inadequately addressed in large-scale family planning/contraceptive (FP/C) programs<sup>8</sup>. A challenge to the implementation of community

participation in health programs is variability, as programs may be viewed as being too "bottom-up" where many components apply to specific contexts<sup>9</sup>.

Participatory programs for FP/C have been challenging in part due to unequal and, at times, conflictual relationships between the health system and community members<sup>8</sup>. Additionally, there is a lack of strong evidence-based foundation for participation in FP/C and inconsistent reporting of outcomes<sup>8</sup>. Possible generalizable intermediate outcomes that reflect community and health system priorities are needed. This qualitative research study was conducted to identify domains, which are defined as possible intermediate outcomes or generalizable thematic areas of action for increasing met needs through community and health provider participation. This formative phase research resulted in the identification of four possible domains for a participatory intervention applied in FP/C programming. They are quality of care, informed decision-making, acceptability, and accountability.

The study was conducted in Kenya, South Africa, and Zambia. In Kenya, it is estimated that 76% of married reproductive age women want to cease childbearing or delay it for at least two years between births, with 53% reporting using a modern method of contraception<sup>10</sup>. The estimated unmet need for contraception among Kenyan women is 18% and 30% among HIV-infected women<sup>10,11</sup>. Unplanned and teenage pregnancies, and unsafe termination of pregnancy (TOP) remain major public health concerns despite a relatively high contraceptive prevalence, and despite TOP being legal<sup>12</sup>. In South Africa, 16% of women aged 15-19 have begun childbearing: 12% have given birth<sup>13</sup>. According to the latest data from South Africa, the overall use of modern contraception remains relatively high (58%) however, 18% of women continue to have an unmet family planning need<sup>13</sup>. Only recently, in many public sector clinics, condoms, combined oral contraceptive pills, and progestin-only

injectable methods have been the only methods available in South Africa; more recently, the hormonal implant has been introduced, and the intrauterine device is more accessible<sup>14</sup>. Despite efforts in Zambia to increase the availability of contraceptives at no cost to users, the prevalence of modern contraceptive use remains low at 32.5% among all women and 45% among married women aged 15 to 49<sup>15</sup>. Unmet need for FP/C services in Zambia stands at 21%, of which 14% are spacers, and 7% are limiters<sup>15</sup>.

## Methods

The study conducted between July 2015 to February 2016 aimed to explore the following topics to inform how the community and healthcare providers (HCP) could be engaged:

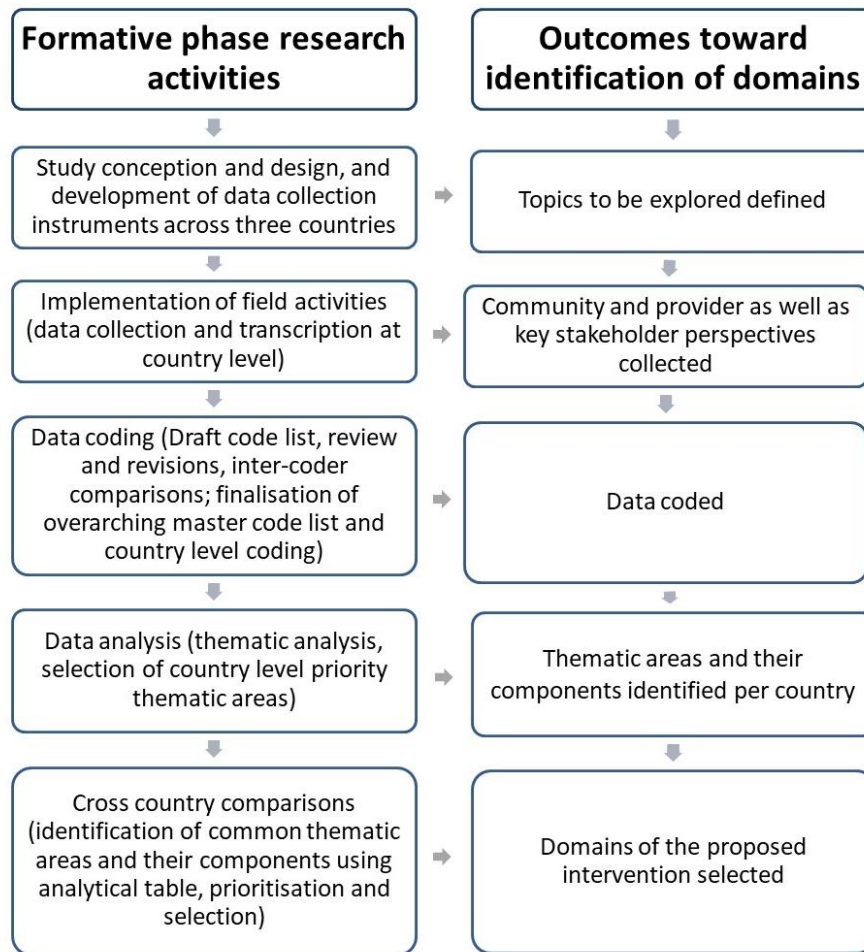
- a. Knowledge, attitudes, and practices in FP/C services and utilization
- b. Barriers/enablers to FP/C service provision/access
- c. Understandings of QoC
- d. Community participation activities and practices

This manuscript reports on an overall analysis, comparing the findings from the three countries. Country-specific findings are also being written up or are published elsewhere<sup>16,17</sup>.

A qualitative, exploratory methodology was used to gain in-depth knowledge and understanding to identify domains for addressing unmet need from the healthcare provider and community perspectives (see **Error! Reference source not found.**). All research teams – one based in each country, were involved in all study activities - from study conception and design, development of data collection instruments, to study implementation and data analysis - ensuring ownership and contribution from multiple sites<sup>18</sup>. In-depth interviews (IDIs) with key stakeholders and focus group discussions (FGDs) with community members (FP/C users and non-users) and HCP were conducted using interview guides for each group.

FGD community participants were purposively selected – i.e., selected to represent categories that were identified as important for the study. Twelve FGDs were conducted per country with male and female community members. Groups were categorized by area (rural/urban), age, marital status, sex, and parity. Two FGDs were conducted per country with HCP participants representing different service delivery categories (e.g., doctors, nurses, counsellors). Each FGD comprised of 7-10 individuals. Healthcare providers were selected from the healthcare facilities in the districts/areas/regions in which the intervention was proposed to be conducted. A range of HCP levels were purposively chosen to represent a range in views. The HCPs recruited were those who were directly providing FP/C services or who were based in other service delivery points which promoted or informed women about FP/C options. Recruitment of key stakeholders was done via snowball and/or purposive sampling to ensure representation of key groups, based on knowledge of experts in the area, as well as key community persons who had influence in the health sector. Eight to ten stakeholders were interviewed in each country. Additionally, Community Advisory Group (CAG) members provided information on and supported access to stakeholders and community participants. The CAG comprised key community representatives (including representatives of youth groups, women's groups, etc.). It was set up to act as a group representing the community, providing community input to the project processes, as well as to provide feedback to the community about the project.

All FGD participants and stakeholders interviewed were informed about the aims of the study and the risks involved in their participation, and all provided written informed consent and voluntarily agreed to participate in the research and to be audio-recorded. Parental informed consent and assent were obtained for participants 15-17 years old. Participants were not remunerated for their participation, however, where applicable according to local ethics committee guidelines,



**Figure 1:** Flowchart of key research activities and outcomes<sup>22</sup>

some were reimbursed for their time and transportation costs. IDIs and FGDs were conducted in either English or local language, or both, depending on the context.

**Study settings**

One district or county per country was pre-selected as a study setting based on the existence of a contraceptive policy, availability of services and infrastructure, including existing participatory structures.

Kilifi County, which is one of the 47 administrative counties in Kenya, was selected to be the study site in Kenya. Kilifi County has among the lowest contraceptive prevalence rates (CPR) in Kenya. For Kilifi County, the CPR is

33% which is lower than the national average of 53%<sup>10</sup>. Kilifi also has high child marriage and teenage pregnancy rates<sup>10</sup>. Among 20,066 pregnancies in the county, 185 are among adolescents between 10 and 14 years old and 3,671 are among women between 15 and 19 years of age<sup>18</sup>.

In South Africa, the eThekweni District of KwaZulu-Natal province was selected as the study site. The eThekweni District is the third largest district in the country, with a population size of around three and a half million people<sup>19</sup>. The couple year protection rate (CYPR) for the district was 66.1% for 2016/2017<sup>20</sup>. Although the CYPR is just above the national target of 50%<sup>20</sup>, the district has seen the largest decrease in CYPR, of

8% between 2015 and 2017<sup>20</sup>. KwaZulu-Natal has the largest number of people living with HIV/AIDS in the country<sup>21</sup>. In Zambia, the formative phase study was conducted in the Katondo area of Kabwe District, which is the provincial capital of the Central Province of Zambia. Central Province has among the highest rates of unmet need in the country at 25.7% second only to Luapula<sup>15</sup>.

### **Data coding and data analysis**

Each country independently reviewed a subset of their transcripts, representing FGD and IDI data and drafted a code list per country team. The country code lists were merged to create an initial draft master code list. Using this draft master code list, an additional subset of transcripts, representing different FGDs/IDIs from each country, were double-coded in each country. Inter-coder comparisons were conducted to provide points of discussion and to facilitate the reliability and validity of coding across countries. There were multiple iterations of the master code list based on data coding and consultations between the three teams. The final code list was applicable to the three countries. Final data coding was done at the country level, facilitated by NVivo 10 (QSR International). Data were thematically analyzed using the theoretical framework of Andersen's<sup>23</sup> health utilization behavior model to guide theme development, as well as *a priori* themes from the study protocol, and themes inductively derived from the data<sup>22</sup>.

### **Data interpretation: identification of thematic areas of action and selection of domains**

Each country team analyzed the data at country level and identified thematic areas of action from which the domains would be selected, using pre-defined criteria agreed upon by the research teams. These criteria included (i) potential impact on unmet need; (ii) whether it was an issue best addressed by community and health system participation and collaboration; (iii) not entailing costly structural changes; and (iv) feasibility. Each thematic area meeting the criteria was triangulated with the HR standards as defined by WHO<sup>3</sup>, to

tease out the key components that defined them. The WHO HR guidelines identified nine standards that include non-discrimination, availability, accessibility, acceptability, QoC, informed decision making, privacy and confidentiality, participation, and accountability. For QoC, the Bruce-Jain framework was also used to identify key components<sup>24</sup>. The Bruce-Jain framework outlined six aspects of QoC, which include: choice of methods, information given to clients, technical competence, interpersonal relations, follow-up, and continuity mechanisms and an appropriate constellation of services<sup>24</sup>. Feasibility of addressing the proposed thematic area at country level was addressed through district/county meetings. During these meetings, preliminary country-level thematic areas were presented to local health system representatives and community stakeholders. The participants were then given the opportunity to discuss and comment on the appropriateness and feasibility of addressing the proposed thematic areas.

Following the identification of the thematic areas in each country, an analytical table was created, summarized in Table 1, to map common themes and components, which led to the identification of four key domains. These domains would serve as the intermediate outcomes of the overall project.

## **Results**

Six thematic areas met the selection criteria. These include (1) QoC, (2) informed decision-making, (3) acceptability, (4) accountability, (5) availability, and (6) accessibility (see Table 6: Summary table of country-level thematic areas covered and their key components).

### **1. Quality of care**

QoC was identified as a key intermediate outcome for addressing unmet need and was purposefully explored. In the three countries, QoC was described by participants as including the way in which FP/C information and services are provided, and the availability of quality methods and services. The Bruce-Jain framework<sup>24</sup> and the WHO HR guidance<sup>3</sup> were used to identify components of QoC.

**Table 6:** Summary table of country-level thematic areas covered and their key components

Thematic Area	Key Components	WHO HR	Bruce-Jain	Kenya	South Africa	Zambia
Quality of Care	Choice of method	Y	Y	N	Y	Y
	Information given to clients	Y	Y	O	Y	Y
	Technical competence	Y	Y	Y	Y	Y
	Interpersonal relations and good customer care	Y	Y	Y	Y	Y
	Follow-up and continuity mechanisms	Y	Y	N	N	N
	Appropriate constellation of services	Y	Y	Y	Y	Y
	Integration of services	O	N	Y	Y	Y
	Waiting times	N	N	Y	Y	Y
	Quality/standard of commodities	Y	N	Y	Y	Y
	Infrastructure - facility, and equipment	N	N	Y	N	Y
Informed-decision-making	Privacy and confidentiality	Y	N	Y	O	Y
	Individual right to choose and be informed	Y		Y	Y	N
	Comprehensive and evidence-based information	Y		Y	Y	O
	Non-directive counseling	Y		Y	Y	Y
	Non-discrimination	Y		Y	O	N
	Health seeking behavior	N		N	Y	N
	Male involvement	N		O	Y	Y
Acceptability	Respect of medical ethics	Y		N	N	N
	Respect of the culture of individuals, minorities, peoples, and communities; sensitive to gender and life-cycle requirements	Y		N	O	O
	Respect confidentiality and improve the health status of those concerned	Y		O	O	Y
	Placing gender perspective at the center of all policies, and services affecting women's health	Y		Y	O	O
	Involvement of women in the planning, implementation, and monitoring of such policies, programs, and services	Y		N	O	N
	Accountability	Monitoring and evaluation	Y		N	N
Availability	Availability of effective processes for remedy and redress	Y		N	Y	O
	Participation of a wide range of stakeholders in the development and implementation of laws, policies, and programs	Y		O	N	N
	User/community accountability	N		N	Y	N
Accessibility	Facilities, goods, services and program	Y		N	N	Y
	A range of contraceptive methods, including emergency contraception, is included in core list of essential medicines	Y		O	O	Y
Accessibility	Physical accessibility of services	Y		N	N	Y
	Economic accessibility of services	Y		N	O	Y
	Accessibility of information	Y		O	O	Y

**Legends:** Y –yes, covered; N – no, not covered; O –covered under a different thematic area

### 1.1. *Need for information*

The need for adequate information and counseling about FP/C was raised by the community and HCPs in all three countries as important for QoC. Across countries, there was evidence that community members needed more information about side effects to make informed decisions about their FP/C use and to facilitate continuation.

### 1.2. *Interpersonal relations and good client care*

Data demonstrated that QoC is linked to the relationship between the client and the provider. In Kenya, community members indicated that HCPs were impolite when talking to clients, resulting in clients seeking services in private clinics. In Zambia, community members underlined the need for being treated with respect, listened to, and given proper information regarding FP/C methods. Good client care is closely related to acceptability of services, including standards of services that consider the needs of individuals. Acceptability of service delivery, especially the attitudes of providers, seems to be an area in need of improvement according to community members in the South African setting. Community members defined poor quality services in terms of poor or negative attitudes of HCPs toward FP/C users and non-users.

Further, in South Africa, it was mentioned that stigma perpetuated by HCPs within healthcare facilities should be addressed. FP/C users and non-users desired to access facilities where they would not feel judged by either community members or HCPs for accessing FP/C services. In Zambia, acceptability was not directly identified as a component of QoC or as a separate thematic area. However, participants did express the need for services that respond to their needs, including the availability of dedicated FP/C space for counseling to ensure privacy. Information to adequately combat negative traditional and cultural beliefs, and comprehensive information on side effects were important components of QoC. In Kenya, acceptability was viewed as a separate thematic area from QoC (see section 3.2).

### 1.3. *Technical competence*

Technical competence of HCPs was identified by various participants in all three countries as a key factor for improving quality of services.

In South Africa, technical competence was mainly raised by HCPs who felt FP/C providers should be well trained and informed to enable them to give accurate and effective care to users. Community members in South Africa male participants mentioned that they preferred to receive services from doctors and technically trained HCPs. High-level stakeholders in Kenya acknowledged that they rarely provide training on the provision of FP/C services to HCPs. Kenyan community participants associated QoC with FP/C provision by trained healthcare personnel such as doctors and clinicians. In Zambia, technical competence was mentioned by both community members and HCPs as a key component of QoC. HCPs in Zambia thought that training in contraceptive methods, like long-acting reversible contraceptives (LARC), was critical to ensure competent FP/C service provision and to increase method choice for community members.

In all three countries, staff competency was also viewed by community members as having an influence on HCP attitudes and how they provide counseling and services.

### 1.4. *Availability of methods and services/choice*

Availability of a wide choice of methods was recognized by study participants in South Africa and Zambia as an important component of QoC. South African community participants and HCPs felt users/non-users should be adequately informed about the range of methods available and then given the opportunity to choose in line with their needs. User choice is an important part of QoC since individual FP/C users have unique needs. In Zambia, the availability of methods with minimal side effects was considered as contributing to good quality services.

Additionally, both rural and urban community members in Zambia regarded facility

infrastructure, including the availability of a dedicated space for FP/C, as important in the provision of quality FP/C services. Zambian participants indicated that sharing of space with other services compromised privacy and limited the time dedicated or availed to FP/C services. Findings from Kenya demonstrate that participants' perceptions of quality are affected by long waiting times, mainly attributed to the shortage of HCPs and heavy workloads, as well as prioritization of other health services over FP/C services.

### 1.5. *Appropriate constellation and integration of services*

Integration of services was discussed in the three sites. However, participants raised concerns about the need for accommodating FP/C only clients and prolonged waiting times when services are integrated (section 1.4). In Kenya, HCPs noted that other departments such as the maternity centers were prioritized more at the expense of the FP/C clinics resulting in long waiting times. Availability of basic equipment such as blood pressure machine(s) and having tests, such as a pregnancy test within the FP/C service, was also viewed as important to quality services among community members in Zambia. Women accessing FP/C services were not happy to have to go to another area in the facility and must wait for additional tests/services.

## 2. *Informed decision-making/choice*

Informed decision-making emerged as a key theme across the three countries. The need for comprehensive and evidence-based information was identified as an enabler for informed decision-making by community members in all countries (and is closely linked to the need for information, section 1.1). The important role of male partners as either decision makers or influencers and the need to involve them was also raised under this thematic area.

### 2.1. *Comprehensive information on methods*

Community members in all countries felt that lack of information played an important role in not

using FP/C or discontinuing. This is despite the finding that most community members across all sites, whether FP/C users or not, were able to name or describe some form of FP/C method.

In South Africa, participants felt that the lack of information on side effects and how methods work meant that community members could not make informed choices. The lack of FP/C information from parents to their children was identified as a concern by both community and HCPs. Older community members who had children reported that it was not culturally appropriate for them to discuss FP/C with their children. Numerous myths and rumours were reported about FP/C use across all the groups in South Africa, including that FP/C can lead to infertility/reduced fertility, bodily harm and effect of increased vaginal wetness (as a side effect) on sexual pleasure, and the ineffectiveness of some FP/C products.

Meanwhile, in Kenya, community members generally viewed that HCP should provide accurate information and the range of FP/C options available, but the client should make the ultimate choice. Some community members cited the failure of HCPs to offer comprehensive information as a major cause why some could not make an informed decision. There were also several myths and misconceptions regarding FP/C utilization reported by the community participants, especially among the youth. These include FP/C causing infertility, promiscuity, birth defects, and general body harm. Additionally, there were variations in the level of knowledge with the adult women appearing to be more knowledgeable about methods and/or services than the males and adolescents. No Kenyan adolescent mentioned a permanent method.

In Zambia, the need for FP/C information was acknowledged by most participants. The predominant sources of information were HCPs. Other sources reported were male partners/spouses, peers, parents and religious leaders. Due to the many sources cited, Zambian HCPs noted an increasing likelihood of misinformation or passing on of myths and incorrect beliefs. For this reason, both HCPs and community members stated HCPs were most competent to provide information of FP/C.



Community members in Zambia reported that HCPs gave information, but they made their own decisions about FP/C use. A need for HCPs to dedicate more time to discuss the different methods with users, as well as, the possible side effects of methods emerged across all age groups in Zambia, including men, who were even less informed about FP/C.

## 2.2 *Male partner involvement*

The role of male partners was a key factor in FP/C decision-making process in all three countries. In Zambia, female participants reported that male partners were crucial stakeholders in FP/C decisions and married women said that their choices were sometimes made with their spouses. For this reason, it was important that men should also be informed regarding the benefits of FP/C and that programs had to involve them in services provision. Male partners' failure to understand FP/C services benefits, lack of information, and general attitude - thinking it was woman's issue - meant informed decision-making was negatively affected. FP/C services were considered to be female-oriented, leaving no room for male involvement. For example, mother and child health clinics, where most FP/C services were offered in Zambia, appear as a service for only mothers and their children as evidenced even by the name.

Some female and male community members in South Africa described the importance of men being involved in FP/C decision-making, and that they should be informed about available FP/C methods and services. Because of the focus on women, men may feel discriminated against when they utilize FP/C services. By addressing this critical issue with HCPs, FP/C programs can be re-organized to accommodate men and their specific needs. Men also played a crucial role in FP/C decision making in South Africa, but women also reported taking autonomous decisions when it came to their FP/C use.

In Kenya, male involvement was identified as a key facilitator for FP/C acceptability (as described in section 3.2).

## 3. *Acceptability*

Acceptability, which is critical to ensuring that services are provided in a way that responds to the needs and culture of the community, was identified as a separate thematic area in Kenya. In South Africa and Zambia, acceptability was viewed as part of QoC.

### 3.1 *Responding to specific client needs*

Respect of culture of individuals, minorities, peoples, and communities; sensitivity to gender and life-cycle requirements, came out strongly from the Zambian data. Respect of clients' privacy was integral to QoC in Zambia and Kenya. For South Africa, respect of individuals' needs, and their culture was viewed as an integral part of providing quality FP/C information and services. In South Africa, acceptability was linked to interpersonal relationships in service provision and included aspects such providers' attitudes and experiences of discrimination that users felt when they utilized FP/C services.

### 3.2 *Male involvement*

There was the consensus among female participants, HCPs, and stakeholders in Kenya that men, as well as mothers-in-law, are major barriers to FP/C uptake. The community takes pride in having many children, and men and mothers-in-law are viewed as critical in safeguarding culture, including deciding the number of children. The HCPs even refer to 'Mwenye (husband) Syndrome,' which applies to women refusing reproductive health services because of their husbands' or partners' opinions. Other women reported using FP/C in secret. Kilifi, specifically, reportedly has low levels of male involvement in FP/C. Lack of information, cultural barriers, and inaccessibility of the services are some of the reasons for low male involvement in FP/C services utilization. HCPs noted that policies on the involvement of men do not seem to be effective and seem to focus only women. In this regard, there needs to be a focus on gender perspective in policies. As described, male partner involvement

was viewed as a key factor of informed decision-making in both South Africa and Zambia (section 2.2).

#### 4. *Accountability*

From the data, accountability refers to personal behaviors of both community members and HCPs. The existence of accountability mechanisms in FP/C programs was identified as a key factor to ensure quality improvement and as an example of community participation.

Community members and HCPs in South Africa talked about accountable individual behavior that can lead to better utilization of FP/C services. The South African community members reported that in some instances they were “too lazy” to go to the clinic and get FP/C, even though the clinic may have been in close by. Furthermore, South African community members recognized the role that they had to play to ensure the proper use of methods. HCPs also have to be held accountable for the services that they provide. Poor HCP attitudes were frequently mentioned as possible barriers to FP/C use in South Africa, and it was suggested that HCPs who displayed poor attitudes should be held accountable.

In Zambia, community members and HCPs underlined the importance of having a feedback mechanism for the existing FP/C services as an example of participation. According to HCPs, communities needed to be sensitized about existing feedback mechanisms. Community members pointed out that community health workers could be used to provide feedback regarding services offered. In Kenya, stakeholders confirmed that HCPs’ attitudes are a significant barrier to FP/C access. As a result, cases have been reported to the county and sub-county supervisors who in turn take disciplinary measures.

#### 5. *Availability*

The availability of both infrastructure and commodities came out strongly in the Zambian context. Mostly, the users reported that there were shortages of FP/C methods in the facilities. These stockouts led to women stopping or becoming dissatisfied with their method. As a result, stockouts were the major reason for discontinuation, other than side effects and myths.

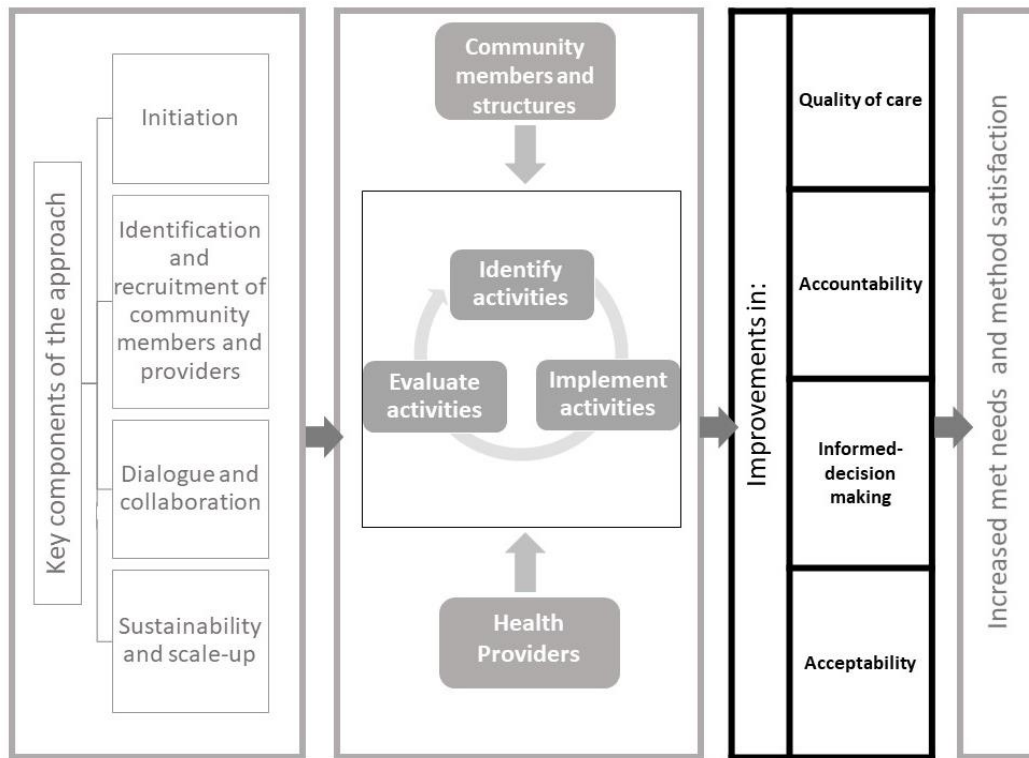
Availability of commodities was not cited as a major issue in Kenya, and stockouts were reported by the HCPs and the county stakeholders to be rare. Although some facilities did not provide LARCs or lacked trained personnel to do so, there were mechanisms in place to refer clients. They were either referred to other facilities or Marie Stopes International in-reach activities. Community members utilized private clinics, pharmacies, and shops when methods such as condoms and emergency contraceptive pills were not available in public health facilities. Community Health Volunteers were also reported to distribute condoms in rural communities and at the beaches. In South Africa, the availability of FP/C was described in a positive, enabling manner. However, it was the way these FP/C methods were supplied or made available that created barriers, rather than the mere absence of methods. For all three countries, the availability of services and a wide range of methods was seen as a key component of QoC (section 1.4).

#### 6. *Accessibility*

In Zambia, accessibility was identified as a separate thematic area by participants given availability issues (section 5) and the shortage of facilities and long distances that users need to travel to access services. The latter also entailed higher travel costs. For South Africa and Kenya, physical and economic accessibility of services did not emerge as a key thematic area. In the two countries, the accessibility of information was raised as part QoC (section 1.1) and informed decision-making (section 2.1).

### **Discussion**

Four possible domains were selected from the six country-level thematic areas identified through discussions by the research teams and by mapping out the common thematic areas across the three countries. The domains are QoC, informed decision-making, acceptability, and accountability. Availability and accessibility are also important thematic areas that need to be addressed to increase met needs. However, community and HCP definitions of availability and accessibility are closely linked to QoC and did not emerge as



**Figure 2:** Theory of Change framework

separate themes in all countries. A theory of change showing how a participatory program involving the community and the health system could address unmet need was developed and refined through iterative consultations with researchers and experts in FP/C, HR and community participation. The four domains identified were used to refine the overall project theory of change, as possible intermediate outcomes (see Figure 2 Theory of Change framework).

Study participants raised most of the components of QoC mentioned by the HR guidance and Bruce-Jain frameworks<sup>24</sup> except for follow-up and continuity mechanisms.

Additional components of QoC were identified in the data, related to acceptability of the services that include respect of needs, appropriate waiting times and respect of privacy.

Informed decision-making was identified as a key thematic area across the three countries. According to the WHO HR guidance, giving each person the opportunity to make autonomous reproductive choices is a human right<sup>3</sup>. To achieve

informed decision-making about safe and reliable contraceptive measures, several requirements need to be fulfilled. These include the provision of and access to comprehensive information, counseling and support for all people, including adolescents, unmarried women, men, people with disabilities, indigenous peoples, ethnic minorities, people living with HIV, and transgender and intersex people. In South Africa, a high level of knowledge about FP/C methods amongst community members correlated with the data reported in the literature<sup>25</sup>.

Strengthening accountability measures was perceived as key for quality improvement and as a mechanism for community and HCPs collaboration in all three countries. Acceptability also emerged as a key domain, with varying focus in the three different contexts. Respect of medical ethics, which is included in the definition of acceptability in the WHO HR guidance<sup>3</sup>, was not addressed by study participants.

Male involvement was raised in relation to two domains: informed decision-making and acceptability. The reasons why there are varying

perspectives on the importance of male involvement point to the difference in gender norms and women's FP/C decision-making capacity in the different settings<sup>10,15,25</sup>. In Kenya and Zambia, male partners strongly influenced FP/C use and decision on the number of children. In Zambia, it was viewed that men should also participate in programs and be informed about FP/C use to increase uptake. While in Kenya where big families are favored, the provision of services and information need to target and be acceptable to men as well as women. In South Africa, where women reported taking FP/C decisions independently, men were viewed as possible facilitators to informed decision-making and source of information. Although the contexts vary, male involvement and gender-neutral FP/C counselling and communications emerged as key issues that need to be addressed.

District/county meetings were held where the country-level thematic areas were presented to the community and HCP stakeholders to establish the feasibility of addressing them using a participatory program. The participants of the meetings agreed on the feasibility and appropriateness of the domains identified. Additionally, participants found the link between the thematic areas and the overall goal of addressing the unmet need for FP/C easy to understand.

In Zambia, it was commented that the possible domains addressed both demand and supply issues which made them appropriate to specific needs in the context. No other domains were suggested. Some concerns were raised on how infrastructure-related accessibility issues would be improved, as they were costly and took time. During the pre-testing process, participants suggested activities that could address the identified domains proving their importance. In South Africa, the participants agreed on the possible domains presented and added that women's self-esteem and own decision-making capability were very important. In Kenya, the possible domains were viewed as appropriate but additional issues were also suggested, such as changing the attitudes of HCP, availability of methods, and provision of youth-friendly services.

To our knowledge, the inclusion of community perspectives in identifying priority areas of action to increase met needs for FP/C is rare. From our literature search on community and HCP understandings of QoC, we found that most of the research on the topic focus on user or client perspectives and thus miss out on capturing the voices of non-users of FP/C<sup>26</sup>.

## Limitations

In qualitative research, the researcher(s) are the primary interpreters of the data. In this study, there was much focus on ensuring that coding was reliably done across countries<sup>18</sup>. As with all qualitative studies, the data is exploratory in nature, and based on a limited number of interviews or discussions, so generalisability of data to the larger country contexts is limited. However, the purpose of this study was exploratory, to inform the development of an intervention in the study areas, not necessarily to be generalizable to other populations. Other thematic areas of action for improving FP/C services may be identified or prioritized in different contexts but as the research was conducted across three different country contexts, allowing for comparisons to be made and similarities to be explored in these contexts. These form the basis for future work to improve FP/C uptake in these areas.

## Conclusion

Although the three countries represent diverse contexts, common domains to increase met contraceptive needs and their components were identified. The participatory process used in this study can help ensure that the domains to be addressed by participatory programs correspond to the actual needs and perspectives of the potential direct beneficiaries from the community and the health system. Consultation of community members, including non-users of contraception, and examination of health system priorities have potential benefits in creating buy-in and identifying context-specific priorities for programs and, ultimately, increasing met needs. These domains provide possible intermediate outcomes

to measure in future research into participation in FP/C programs.

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## Authors' Contribution

The study design was conceived by PSS, JPC, JS, PG, TN and JK. The UPTAKE Project country team members (JS, CM, YK, PG, IN, TN, AS, MM) contributed in data collection and country-level data analysis. All authors contributed in the cross-country comparisons. JPC drafted the manuscript with input from the UPTAKE Project country team members and all authors reviewed and approved the manuscript.

## Authors Statement

The authors alone are responsible for the views expressed in this article, and they do not necessarily represent the views, decisions or policies of the institutions with which they are affiliated.

## Ethical Consideration

This study received WHO Ethics Review Committee (ERC) (A65896) and Research Project Review Panel (RP2) approval. Relevant country and institutional review boards also reviewed and approved the study protocol (Kenyatta National Hospital/University of Nairobi Ethics and

Research Committee (KNH-UoN ERC); University of Zambia Biomedical Research Ethics Committee (UNZABREC) and the University of the Witwatersrand Human Research Ethics Committee (Medical)). All participants (>18 years) provided written, informed consent to participate in the study. Participants who were under the age of 18 years provided written assent, and their parents/guardians provided written consent for their participation. If participants were not literate, a witness was required to be present during the consenting process and sign consent on their behalf. The participants also gave separate consent to being audio recorded.

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