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Modern Birth Control Methods, a Discourse of a Sub-Saharan African Rural Community: The Case of Minembwe, Drc

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ABSTRACT

Despite the numerous benefits of modern contraceptives, low uptake of family planning has been a major challenge in Sub-Saharan Africa rural communities. This qualitative research was conducted to assess the views and belief of communities in the rural commune of Minembwein the Democratic Republic of Congo on modern contraceptives. A purposive sampling technique was to conducted the qualitative study comprising four Focus Group (FG) members, and eight Key Informant Interviews (KII) members. Qualitative data were obtained from FGDs made up of a group of women and men, local leaders and other local actors such as representatives of faith-based organizations (FBO) and civil society organization (CSO), the priest of the Catholic parish, some pastors of the dominant churches and local chiefs. The discussion was digitally recorded in Swahili and Kinyamulengeand later translated into English. Data were analyzed using the content analysis method. The major barriers to the use of family planning were religion inclination, husbands being the decision makers, fear of side-effects, desire to get more children in anticipation of a better future and sociocultural norms-fear of discrimination. The poor acceptance of modern contraceptives was not limited to couples, but to the entire community. It is necessary to create more awareness of modern contraceptives in rural communities of Sub-Saharan Africa to trigger behavioral changes in their perceptions on family planning. It is also important to address the persistent socio-economic and cultural challenges in order to promote mutual understanding, awareness, and cooperation in regards to the uptake of modern contraceptives.

INTRODUCTION

The decision for couples to freely choose the number of children and spacing pregnancies continue to be an issue in some settings, particularly in the African context where traditional culture, religious belief, social environment, and gender equity deeply continue to influence lifestyle and health behaviors. This matters as it reflects the extent to which women have the power to make decisions and independent choices pertaining to the number, timing, delaying and spacing of their pregnancies [1].

Contraception is a term that is rarely defined but used to mean a range of interventions that are commonly used to control births. Accordingly, family planning (FP) refers to the use of modern or traditional contraceptive methods undertaken with the objective of preventing unwanted pregnancy, regulating a number of births and family size, and spacing pregnancies[2]. For the sake of differentiating modern versus traditional contraceptives, the modern contraceptive is considered as any product, method, medical device or procedure that averts pregnancy or interferes with reproduction after sexual intercourse[3]. Examples of modern contraceptive methods as described by Hubacher and Trussell[3] include oral contraceptives with pills containing hormones; long-term birth control method such as the use of Norplant, Depo-Provera, or Intrauterine devices; female and male sterilization; condoms use; and diaphragm insertions to name a few[3].

Though this definition was adopted, there is still worldwide confusion as to what is modern and what is not, between organizational and scientific perspectives. According to Kalipeni and Zulu, any other intervention that does not fit the above definition has long been considered the traditional or non-modern method, these include- but not limited to- withdrawal during the sexual course, periodic sexual abstinence, prolonged breastfeeding, and the wearing of traditional beads [4]. However, this classification does not consider the effectiveness or efficacy and modern does not mean more effective method.

The benefits of the use of contraceptives are numerous; many studies have reported a positive impact on individual, community and global development efforts and thereby seen family planning as the key to family's wellbeing, to minimize women's health risks, to increase women's productivity, to decrease infant mortality rate and to ensure the autonomy of women[5,6]. Family planning is embraced as a moral good, responsible choice, and basic

human rights; and enables couples to bear children during their healthiest times for themselves and their children.

If a woman has access to voluntary family planning and services, and reproductive health information, they can plan their lives without being unacceptably subject to sexual and social constraints, thus an indication of how much power and means women have to freely make their own decisions in regards to the number, timing, and spacing of births [4]. Family planning does more than saving lives and matters for societies as it can negatively or positively impact progress toward prosperity, equitable and sustainable development, as well as well-being for all[1]. Although family planning policies have changed over the years and reports indicate an increase of family planning services use, average family size in the DRC remains large, and the need to space children is still paramount.

The Minembwe Rural Commune with an estimated population of over 30,000 people is a part of the rural and enclaved areas of DR Congo, situated in the South Kivu province and administrative Territory of Fizi. This area is characterized by poor education and there is a disparity in education by gender. Also, little activities have been undertaken to address the sexual and reproductive health problems with significant impact hitherto in this Zone. This study was conducted to assess the availability and accessibility of sexual and reproductive health services and informs policymakers on the gaps in the family planning policy, reproductive health policy and other policies that affect young women's reproductive health and contraceptive needs.

METHODOLOGY

A purposive sampling technique was used to determine the sample size for this qualitative study comprising four Focus Group (FG) members, and eight Key Informant Interviews (KII) members as presented in Table 1. Qualitative information was obtained from FGDs made up of group of women and men, local leaders and other local actors such as representatives of faith-based organizations (FBO) and civil society organization (CSO), the priest of the Catholic parish, some pastors of the dominant churches and local chiefs as they are very influential on social, cultural and religious levels. Similarly, direct interviews were organized with KII.

The qualitative approach was important in a way to allow the validation, triangulation and yield explanation for some key conceptual and perception results. The qualitative approach

enables researchers "to learn or confirm" not just the facts (as in survey method), but also the meaning behind the facts. This conveys a major advantage: the production of insight"[7]. FGDs allow the richness and flexibility in the collection of data that are not usually achieved when applying an instrument individually; at the same time, it allows the spontaneity of interaction among the participants.

Based on identifying indicators and related source of data, interview guides were designed and used twofold: first, the tool helped in guiding the FGD in order to avoid disconnection from the central topic. Second, it was used during interviews with key resource persons who were contacted to provide their perceptions vis-à-vis family planning in general and contraceptive methods in particular. All study procedures were conducted in private rooms to maximize confidentiality and comfort of respondents. Respondents participated in one day-long mixed-gender discussion.

Homogeneous FGD was conducted, where the group consisted of one gender, church leaders, community leaders; and heterogeneous FGD, where the group consisted of people with different demographic characteristics. The principle of homogeneity guided the research team in terms of involving participants in FGDs. Heterogeneity in FGD, on the other hand, allowed the research team to assess the level of consensus around different themes or topics discussed, and interpretations as well as opinions about the same themes. Also, the homogeneous composition of FGDs enables the research team to make comparisons and analysis patterns across the participating groups.

The FGDs were divided into sessions by topic and included the following topics: contraceptive knowledge, issues related to health care and family planning services access, health-seeking behaviors and social/spousal support, issues about children, relationships, sexual relations, and future desires. Each session was moderated by one trained male or female using a topic guide, assisted by a note-taker and discussions were tape-recorded.

The research team purposely sampled key informants to take part in KIIs on a one-on-one basis. A total of 8 KIIs with women/men were conducted to minimize the possibility that important information was missed due to group dynamics. The KIIs were conducted by a different interviewer, who had not been part of the FGDs. As the guiding principle of Participatory Action Research, selected participants as key informants were considered as experts in the subject matter, each with regard to its membership component.

Both FGD and KII allowed the research team to garner in-depth views, the discussion was digitally recorded in Swahili and Kinyamulenge, transcribed verbatim, and translated from Swahili and Kinyamulenge into English for analysis. Data were analyzed using the content analysis method.

Table 1: Number of FGD, KII, and Participants

Category	No. of FGD & KII	No. of participants
FGD with young women (under 40)	**1**	**8 young women (under 40)**
FGD with young men under 40	**1**	**8 young men under 40**
FGD with women over 45.	**1**	**8 women over 45.**
FGD with men over 45.	**1**	**8 men over 45.**
Total FGD	**4**	**36 Members [16 women &16 men]**
Religious representatives	**4**	**1 priest of Minembwe Catholic parish (M), 2 pastors of 2 protestant churches (M) &1leader of faithful's women from a Christian church (F)**
Development actors representative	**1**	**1 A representative of Faith-based organizations (FBOs) (F)**
local Administrative authority	**2**	**1 traditional chief of village(M)& 1 local Administrative authority (M)**
Health Sector representative	**2**	**1 Medical doctor (the Director of Minembwe Hospital) (M) & 1 midwife (F).**
Total KII	**8**	**3 Women & 5 Men**

RESULT

Respondents attitude towards family planning

Men and women with whom Focus Group Discussion (FGD) were conducted seem to have mixed feelings about Family Planning. This study found a broader consensus regarding attitude towards FP, but only when it is a matter of space births. This idea is well perceived

by all the layers of the population encountered, from religious leaders and community leaders such as administrative leaders to other members of the community.

The fact is that the people of Ninembwe recognized the benefits of spacing births, especially, the health of the mother and child. The spacing of births is therefore actively pursued in this rural and very isolated area of the DRC. ***"A couple who has managed to observe considerable waiting times (at least two years) between two births is a subject of mockery by the neighbors",*** **recognizes a KII, a faithful woman from a Christian church.**

People's view of FP from a religious perspective

Family Planning in Minembwe remains a topic for which a segment of the population opposed due to the fact that contraception, especially the use of modern contraceptive methods is perceived as a sin and having a family of big size is seen as a blessing.

For many, Family Planning is a synonym to not wanting children, and as being against God's plan for the family, which is an idea that is not tolerated. Therefore, FP is vigorously fought by everyone, including religious leaders, village elders and other opinion leaders, especially who have considerable influence on their sons, and daughters.

People feel that FP remains a difficult issue to deal with in this environment so much the community concerned is immersed in religion. Everyone agrees that even health providers, including medical doctors do not speak openly about FP, especially when they are addressed to men, knowing that men remain pronatalists**.** ***"A man with many children is much respected," told an FGD member, a man.***

Women and men kept mentioning a Bible-inspired message that dominates, influences and guides the attitude and behavior of Christian men and women of Minembwe. The message says that we must procreate and fill the world. ***"Be fruitful, multiply, fill the earth ..." (Genesis 1:28)*** and they added, referring to the Bible(Matthew, chapter. 6:25-26)***, "…do not worry about your life, what you will eat or drink; or about your body, what you will wear. Is not life more than food and the body more than clothes? Look at the birds of the sky: they neither sow nor reap, and they gather nothing into granaries, and your heavenly Father feeds them. Are not you worth a lot more than they?***"

It was expressed that men are less exposed to FP messages. ***"It must be recognized that men are less exposed to messages related to FP topic".*** Health providers are reluctant to talk publicly about FP, especially when they have an audience of men. While women have the opportunity to be reached by FP messages during pre-natal consultations or during maternity in health facilities, they do not have the audacity to talk to their spouses about it.

However, there were some supportive arguments vis-a-vis family planning. A man said: **"*We have a serious problem with religious belief and the related biblical passages interpretation vis-a-vis FP that God ordained people to procreate and fill the world. Thus, any dissonant voice is perceived as contradictory to the Gospel which leads to a big barrier to promote FP".*** The same man went on to say that unfortunately, preachers forget to mention other related biblical passages that recall parental responsibility vis-a-visthe basic needs of their children. He said, "***One day my daughter asked me to enroll her in a school of her choice. I replied that I was unfortunately unable to bear the blow of his school fees in the mentioned school due to the fact that it's very expensive for me. Her reaction was to ask her mom why we (me and her mom) could let her be born while we were well aware of our inability to bear the burden of schooling!***" All participants recognized how It's painful for a parent to get that kind of question from their child and argued that a sensitization campaign to promote FP has to be developed and implemented starting with religious leaders.

One participant said, ***"In the history of the community in this geographic area, civilization came with Evangelization and the churches. Thus, citizens believe that correct ideas come only from religious leaders.***"

The desire to have many children in anticipation of a better future

Reacting to the question related to the perception of the population concerning the heavy burden of parents to support the expenses related to the care (live) of their children (nutrition, health, schooling, etc.), and prepare them for a promising future, some people see the need for FP as just a false debate. They mentioned some children from large families (from this village and neighboring villages) who became rich, and in particular, cadets who became richer than their elders to justify the importance of having the maximum possible number of children. As if to say that if 'we had limited births, these (younger) children, who become wealthy and useful for their families, would not be born'. Thus, it would be a loss to their families.

Other people believe that FP is a message from people who have land problems. ***"We don't have any land problem here. We must procreate many children because; there is still space to live. It's not like in the western world or in the big cities of Africa, where people jostle for a small piece of land ".***

Other reasons mentioned to justify the need for a rich reproduction in this southern part of the South Kivu province included repeated armed conflicts with many of their children died in the war. As a result, influential people carry messages for spanking, and even urge women to procreate, as a way to fill the gap left by those who died in the war. ***"In our context of chronic insecurity, we must have many children because some may die, so, others will stay alive". The statement was from an FGD member, man.***

Attitude towards the use of Contraceptive Methods and a Practice of Immorality

Overall, participants showed less favorable attitudes towards modern contraceptive methods. This negative attitude is motivated by a number of reasons mentioned below:

The use of contraceptives was found by a large proportion of Minembwe citizens as an immoral and unsustainable practice. Women who are acknowledged by their neighbors as using modern contraceptive methods are considered social deviants.

A woman referred to the discrimination experienced for births spacing said; "***One day my friend who used a modern method of contraception to space births had fun to take a baby of our neighbor and began to sing to him. The reaction from that baby's mother was very wild against the woman who held her baby in her hands. She asked her, astonished how can she pretend to show love and affection to her baby when she no longer wants to have children!"***

In this context, the use of modern FP methods is perceived as a behavior observed among women who do not want to obey God's instruction about reproduction, or for female sex workers (prostitutes) who want to have sex but do not want to have children.

In both cases, the use of modern methods of contraception is criminalized and leads to fewer women wishing to use modern contraceptive methods requesting modern PF methods in a clandestine way.

It was recognized that there are increasingly a number of women who are "clandestinely" resorting to modern FP methods for fear of being identified and discriminated against by their neighbors. Some of them were taking advantage of trips out of the Minembwe area to acquire desired modern methods far from their villages. Others try to find a pretext for medical consultation in the local health facility, and thus, to ask for contraceptive methods in a total secret.

One health officer said, ***"One day, I received a couple in consultation. The woman told everyone that she was going to see the medical doctor to treat the so-called headaches. But in fact, when I had an interview with her in my office, confidentially, she told me she came to look for a modern method of contraception".***

Another reason is the focus on side effects of modern contraceptives. Modern methods of contraception are in the collective imagination known only for their side (adverse) effects rather than for their therapeutic virtues in preventing an unplanned pregnancy and some see it as responsible for many health problems.

"In most cases, contraceptive methods lead to infertility in women who use them instead of meeting their need for birth spacing. A woman from my village who has only two children used modern FP method to space births. Since then, she has not had the chance to have another pregnancy, even though she wishes to have one. Her husband decided to get children from other women. Since then, this woman has become the subject of mockery from other women and men that are hostile to FP. She has since become a bad example against the use of modern methods of FP"-A statement of a woman in an FGD session.

In this context, it is argued that women who use modern FP are discriminated so that people assume that they are, by their behavior, responsible for all the things that can happen to them (illness or the death).

"If it ever happens that a woman who uses modern FP gets sick or dies for one reason or another, it will automatically be interpreted by the population as a direct consequence of the use of the modern contraceptive method, and thus, as a sanction of God against the woman concerned".

DISCUSSION

In many Sub Saraha countries including DRC, women constantly face health risks and suffer from various forms of Sexual Reproductive Health (SRH) unsolved challenges. This situation is more puzzling in rural and remote zones of the western part of the country, where a poor health system has been profoundly affected by pervasive civil war since 1996 [8].

This is the first study to investigate the perceptions, uses, barriers, and facilitators to the SHR as well from the perspectives of the women in reproductive age, communities and health care providers in selected villages and facilities of Minembwe Commune. It is vital that women need to have clear and accurate understandings of what SRH and FP mean, where to seek services since such perceptions guide one's own sexual behavior and practices.

Brief historical background on family and reproductive health

Until early 1950s, many of tribal communities including the Banyamulenge in the landlocked of Minembwe practiced their traditional religions. Polygamy, levirate marriages and sharing spouses among peers were practiced. According to customs, peers of the same large family could exchange spouses for sexual intercourse, and children born, still belonged to the family. Identity was vested in the extended family rather than in the nuclear family. This way of life enabled impotent men and widows to have children born to them [9]. The cultural practices of levirate marriages intended to ensure socio-economic prosperity and protection for the family and perpetuated the offspring of the deceased husband. The society was built on family, clan and community [10]. Community leaders were classified according to their wealth: number of heads of cattle and the size of the family (children and other family members) he belonged to. The bigger the family, the wealthier an individual was considered.

Polygamy was highly preferred. Men whose wives gave birth to many girls were forced to marry multiple wives to maximize their chances of having boys. Boys incarnated family succession. In one of their rituals, community members invoked God through *Ryangombe* for blessings: many children, herds of cows and protection from illness. Family planning had no place in community affairs. But there were traditional methods used. Women spaced their pregnancies with prolonged breastfeeding, although this did not always work with everyone. There was also a tradition to abstain from sexual relations for months after birth. This process is known as *kujakuriri*. The woman would be in a separate house or a separate bed to avoid any sexual contact with the husband. This was well managed because the husband would still

be involved with other strong and healthier wives as the mother recovered and gained strength.

But between 1945 and 1980s, the majority of rural populations were converted to Christianity and belonged to a number of church denominations [9]. As the church grounded in local communities, its rules and doctrines replaced their cultural values, which caused a big shift in lifestyle. The church taught about radical change from local traditions to Christianity. This new religion preached against sexual relations outside recognized marriage by the church. This new lifestyle introduced another phenomenon in family setting. For fear of church traditions (sin and shame), parents introduced their children to early marriage life. Of course, it reduced sexual temptations for adolescents and allowed them to have children for the family at early age. According to Elengemoke, at al 2017, 74% of girls and women between 15 and 19 years old are married in DRC. This practice, however, does not go without consequences on young girls who became underage mothers.

The wars of 1990s and onwards, in the Great Lakes Region of Africa and the Rwandan genocide provoked unprecedented human displacement across borders. Thousands of youths enrolled in armies. Local communities became highly exposed to health vulnerabilities due to effects of these wars and cross-cultural influences. Moreover, the number of widows and orphans rocketed high. It is estimated that over 2500 widows in active age of reproduction (16 to 45 years old) were identified in Minembwe and neighboring locations and majority being victims of wars. Rape, sexual violence, promiscuity in refugee and internally displaced camps and poverty, increased risks of having undesired pregnancies and babies whose identities are not known. These crises not only destroyed countries but also cultures and societal values that protected communities.

Factors influencing the uptake (use) of family planning services

The findings of this study show the usage of the FP services was low. The study contributes, however, to a growing body of research on barriers to contraceptive use in rural populations of sub-Saharan Africa. Major reasons cited for not using service included sins against religious beliefs. These arguments were also found in similar studies – in different contexts, but similar settings- by Apanga and Awoonor-Williams [11], in Ghana Mohammed, *et al.* [12], Awusabo-Asare*et al.*[13], Meka *et al.*[14]in Nigeria, by Gebremariam and Addissie[15]in Ethiopia and in DRC by Muanda*et al.*[16]. In this part of the world largely

dominated by Christianity, religious leaders use their speeches to position themselves against family planning. Roman Catholics, Evangelical Christians, and Muslims are therefore forbidden to use any contraceptive methods; they teach that the primary purpose of sexual relations is procreation within marriage. Natural contraceptive methods such as abstinence and the rhythm method remain permissible. They consider any use of modern (or non-traditional) contraception in marriage as an offense against God who gives life. Although their attitude seems to be evolving gradually, notably by allowing couples the freedom to manage their fertility, particularly with regard to birth spacing, they remain hostile to any use of modern contraception, because it is perceived in a wide range of intentions to limit or stop births by women who use it. That means the use of contraceptive methods to refuse the gift from God which, is none other than the child for married couples.

Similarly, the violation of traditional norms or fear of being perceived by their environment as socially deviated women was a very important factor that prevents women from taking modern FP; which leaves them exposed to a very high risk of discrimination in their own community, including their families and members of their churches. These findings are consistent with studies conducted in Ghana, Nigeria, and Ethiopia, which indicates that these countries place a high value on large families and especially male children, and therefore, there is a lack of support for women's use of birth control. Also traditional and familial pressure has been demonstrated to influence the decision to procreate (Mohammed *et al.*, 2014; Gebremariam and Addissie, 2014; Awoonor-Williams and Apanga, 2018; Muanda*et al.*, 2017)[11,12,16],. For instance, some people think that the use of contraceptive methods is perceived a behavior for female sex workers or prostitutes. If we consider the vulgar nature of prostitution in an environment where, according to our study, women are actively religious, and prostitution as immoral in this community, we can realize how much the use of FP would be compromised.

In addition to religious and traditional issues, desire to have more children, husband opposition and lack of women's decisions, cultural norms that support large families were revealed as a major barrier in FP uptakes. Some people revealed that having many children is more justified as a way of perpetuity of the family, but also a sign of blessing and a factor of consideration by family and by other community members; a perception shared by many studies from sub-Saharan countries [17], leading to women opting for conservative attitudes, practices accepted by all. Nobody has the right to make the mistake of moving away from

"what is accepted" at the risk of being marginalized. Several other studies in other sub-Saharan African countries support the suggestion that male's opposition, lack of female's decision and husband's role as the primary decision-maker to opt family planning can hinder uptake and continuation of contraceptive us [16-19]. Such argument as "My husband doesn't allow me to use contraceptive methods" was cited by two in five respondents who reported that they did not use contraceptive methods because of opposition from their spouses, but not mentioning in reasons.

In situations where men have been unanimous in their belief that using contraceptives gave room for infidelity on the part of the woman, a large number also have demonstrated to believe that joint decision-making and truthfulness could help limit some of these suspicions and fears leading to non-use [16], [18]. Indeed, while it has been shown that the man is the one who makes decisions at the household level, including the decision to use the health services, it is obvious that the weak power to negotiate with his spouse on the topic of the PF impact on the behavior of families who are reluctant to embark on a path without support from the spouse. It is therefore important to emphasize that the husband's (men partner's) attitude towards family planning is very determinant when women hesitate from their own initiative to set off a debate around FP with their husbands while recognizing that the decision-making power within couples belongs to men. This argument is in line with the observation made by Allen *et al.*[20] in Uganda and Awoonor-Williams and Apanga, in Ghana [11]. This is a major constraint as women in these settings cannot make decisions for themselves without the approval of their husbands, who are regarded as the head of the family.

This study noted that fear of the side effects is seen as a determining factor in the non-use of modern FP by women. A significant proportion of women are haunted by the widely held belief that modern contraceptive methods are responsible for the health problems of women who use them, including hormonal dysfunction, that cause abortions in the case of women, and some respondents mentioned weight loss or weight gain. Failure of the method on the occasion of the next desired pregnancies after the abandonment of the method and that at worst, they even lead to infertility. This finding is in line with studies conducted in Ghana, Uganda, Malawi and many other countries as all of the studies showed that fear of side effect as a barrier to use such services [21-22]. This might be due to the fact that pregnancy

counseling, education, including preconception care is not being given in the family planning unit, women who used family planning might have information regarding preconception care.

CONCLUSION

The findings of this study suggest that it is necessary to create more awareness of modern contraceptive methods in rural communities of Sub-Saharan Africa. There is a need for enlightenment and make policies that will increase the behavioral changes in perceptions of rural people on family planning. It is also important to address the persistent challenges associated with rural communities in order to promote mutual understanding, awareness, and cooperation in regards to the uptake of modern contraceptives.

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Conflict of Interest

No conflict declared.

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