USAID TULONGE AFYA

Family Planning Audience Insights | Summary Report

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Family Planning Insights Activity Overview

Social and behavior change (SBC) campaigns may start with listening to the hearts and minds of the target audiences. Without knowing what audiences feel, think, and believe, it is a challenge to create impactful SBC messages, activities, or strategies. However, asking straightforward questions often leads to straightforward lies. The "lies" audiences may tell in traditional focus group settings may be a deliberate attempt to role play for the moderator or group, with the intent to look better or smarter, or may be to protect their most intimate fears. Research suggests that 95% of decisions are based on subconscious or unconscious motivators and not logic and facts, so respondents may also simply be unaware of how they really feel about an issue.

Projective techniques

For years, researchers have relied on straightforward questions to gather data. Creating messages and activities on data that didn't represent respondents' truth rarely led to desired social and behavior changes or effective campaigns.

Projective techniques are questions that have no obvious answer. No one knows the correct answer to questions like "if behavior change were a car, what kind would it be." Because respondents don't know the "correct" answer, they project from their truth. This results in rare insights into the deepest desire of the heart, rather than superficial and often untrue data. This also provides program and message developers fresh and unique insights to inform message and campaign strategies.

Audience Insights Objectives

The goal of the Family Planning (FP) audience insight gathering was to determine the emotional drivers of audiences related to priority FP behaviors. Key behavior changes for each target group are listed below.

Unmarried youth, 15-17 years

- Talk to your partner about family planning use before having sex
- Seek appropriate counseling and information on FP options and/or side effects
- Use a modern contraceptive method to delay first birth until after the age of 18
- Consistently and correctly use a condom at every sex

Unmarried, single young adults, 18-24 years

- Talk to your partner about family planning use before having sex
- Seek appropriate counseling and information on FP options and/or side effects
- Use dual methods (e.g. condom plus other modern contraceptive method) to protect against pregnancy and HIV/STIs
- Consistently and correctly use a condom at every sex

Married or co-habiting young adults, 18-24 years

- Talk to your partner about family planning use

- Seek appropriate counseling and information on FP options and/or side effects
- Use a modern contraceptive method to delay and space births

Post-partum women, including those with only one child and those with 3 or more children

- Talk to your partner about family planning use
- Seek appropriate counseling and information on FP options and/or side effects
- Use a modern contraceptive method to avoid pregnancy for at least 24 months

Facility-based health workers

- Support the use of modern family planning methods among adolescents and youth
- Promote a diverse menu of family planning methods to help adolescents and women select the best method for them
- Provide quality, unbiased counseling to adolescents and youth on family planning and reproductive health issues

Approach

Design and Planning

USAID Tulonge Afya developed discussion guides for each target audience segment (see table below based on FP audience insights objectives, background on the FP context in Tanzania, and priority behaviors the project aims to address. The discussion guides were then reviewed and revised before being submitted to FHI 360's Office of International Research Ethics (OIRE) for review and non-research determination, which was approved.

Participants

Participants were selected from primary and secondary target audiences: unmarried youth ages 15-17 years (male and female), married and unmarried young adults ages 18-24 (male and female), and post-partum women (first child and 3 or more children), and facility-based health workers.

Recruitment

Prior to recruitment of participants, the USAID Tulonge Afya team introduced the insight gathering activities to Government of Tanzania partners, and secured an approval letter that was used with Regional, District, and community leaders. USAID Tulonge Afya staff developed a recruitment guide that was used by all recruiters. Recruitment of participants took place in coordination with the Regional and Council Health Management Teams, USAID Tulonge Afya zonal staff, and community health workers. Recruiters asked potential participants for verbal agreement to participate in the activity but collected no demographic information in order to maintain confidentiality.

Insight Gathering Process

For all audience groups, small group discussions were conducted. Thirty-six audience consultations were held with a total of 209 respondents in Musoma Municipal Council and Rorya District Council in

Mara Region and Geita Town Council and Bukombe District Council in Geita Region. Sites were selected in collaboration with the Ministry of Health's Reproductive and Child Health Section (RCHS) and District Medical Officers. In all cases, conversations were directed by a trained facilitator in Kiswahili using audience-specific projective discussion guides. All interviews and discussions were audio recorded for later reference. After the interviews, moderators participated in an in-depth de-brief with experienced team leaders to tease out key information and insights. Moderators also completed a written de-brief form to document their impressions of the session and key findings that arose during the activities.

Analysis

The traditional approach to analysis is logic based. Behavior change analysis is emotion based. To start the analysis in an emotion-based arena, the following springboard questions were used to gather information from the facilitators about each interview or discussion:

- What surprised you about this group conversation?
- What was upsetting to you about the group conversation?
- What about this group conversation made you happy or gave you hope?
- What did someone in the group say that you will never forget?
- Was there an emotional reaction to any of the conversation topics? Tears? Anger? Surprise? Disbelief? (Positive or negative)
- What are three key findings that were uncovered in this group?
- What was the most powerful emotional "heart buttons" for this group? Help me understand that choice.
- What other emotional "heart buttons" were important? Help me understand those choices.
- Please share other important thoughts or comments that would help me understand this group conversation.

While these questions helped to target emotional responses, the team leads followed up these questions with targeted probes and logic-based questions as needed. The team leads then compiled and summarized the information from the debriefs into an insight report that will be used to draft creative briefs for each target audience.

Findings

When presented with a behavior change opportunity, people ask themselves these three questions when considering the change:

- What's in it for me to change?
- Why should I believe you?
- How will taking action solve a problem in my life?

This activity provided insights into these questions so that project behavior change messages and strategies can be developed to incorporate answers to these questions in subtle yet effective ways.

What's in it for me to change?

USAID Tulonge Afya's FP activities will target a range of behavior changes. Although the specific behaviors are different, the emotional drivers of related behaviors within targeted groups are likely to be the same.

1. Unmarried Youth, 15-17 years

- Adolescent girls and young women
    - **Belonging**: Unmarried girls in this age range are very conscious of their **dependency on their parents and community for support** and future opportunities, such as being able to finish school and finding the right kind of partner. Girls are very concerned with being **perceived as "good girls"** and being associated with other "good girls," and they feel **immense pressure to give the image of complying with social norms around abstinence**, even if they are secretly engaged in dating and sex. They **fear loss of support** from their family and parents above all, and for those still in school, they **fear being kicked out of school** and **losing face** in their community and family if they were to become pregnant. They want to be sure their activities are **seen as "normal" or appropriate** for girls, but they see **FP as something that is for "women"**. Many girls speak of finishing school and/or having her own successful business so others will look up to her and her parents will be proud. Young women want to avoid being forced into marriage with a "boy", and wish to have a good husband and family with a nice house, nice things, and everyone will **recognize she has a "good life"** (*maisha mazuri*).
    - Secondary drivers: **Status, achievement, recognition**
- Adolescent boys and young men
    - **Status:** Especially for those out of school, young men in this age range are in the beginnings of **wanting to be seen as "men" instead of boys**. They are very concerned with fitting in with their friends and buy into potentially harmful gender norms about what it means to be a man (Box 1). Young men **rely on friends** for information about condoms and talk to friends about having sex without condoms, likely reinforcing harmful norms. Boys also **crave financial success so they can fulfill scripted roles as providers** (nice cars, clothes, house) and strong authoritarian figures in their family, and be recognized by their families and communities. For boys in-school who are still living with their parents, ensuring they do not risk being kicked out of school, forced out of the home, or even jailed for impregnating a school girl, were strong motivators for avoiding pregnancy (or denying a pregnancy). In more urban areas, boys **dream of being entrepreneurs and "bosses"; in more rural areas, boys look to have salaried, steady jobs**.
    - Secondary drivers: **Belonging, achievement, recognition**

Box 1. Gender Norms Surrounding Masculinity

Deeply held beliefs about how men should behave were recurring in group discussions with men of every age and life stage. These beliefs were common across locations and age groups and are connected to men's emotions and actions around family planning behavior. Normative masculine traits described by unmarried young men included:

- Young men's sex drive is so strong they cannot stop themselves to put on a condom;
- Young men's sexual pleasure is so important, it overrides all the myriad reasons they give that it is better to prevent pregnancy. They will go so far as to lie to girls about how condoms work, lie about the effectiveness of withdrawal, deny the baby is theirs if they do withdraw (even though they know it could be theirs), harass and pressure a girl to have sex without a condom until she just "gives in";
- Young men cannot ask a medical provider for advice about condoms or other methods because men do not go to health facilities and FP is for women. They also don't want to be seen in shops buying condoms;
- Young men must achieve financial success before becoming married, because it is their job as men to be providers;
- Young men make the decision about whether to use condom or not.

2. Unmarried, single young adults, 18-24 years

- Young women
    - **Independence/control**: Unmarried young women in this age group are **struggling to find stability in a period of transition**. While many of their peers are already married and having children, they **want to make it "on their own".** They are establishing themselves as independent from their parents and have seen that men cannot be trusted. Many talk about wanting to be entrepreneurs or finishing school and being seen in the community as successful and independent, all of which will help her gain a happy marriage with a good partner who really cares, and not be saddled with a husband who will control her, not respect her, and possibly beat her. While they want to wait to get married and have children until they have "made it" and have some status in their marriage (due to their independent income), if they were to become pregnant now, they say they will make it work. To them, it is "**normal" at this age to be having babies**. They are curious about pregnancy prevention methods, but are **ambivalent on who to trust and where to go** for methods or information.
    - Secondary drivers: **Achievement, recognition**
- Young men
    - **Status**: Like younger boys and men, unmarried men in this age group continue to try to **establish themselves as transitioning into adulthood, including buying into gender norms about men's sexuality and dominance** (see Box 1). Having multiple partners and talking about having sex without a condom establishes him as "cool". More so than younger boys and men, they discuss establishing **dominance within relationships** and controlling their female partners. They describe complex decision

trees around condom use with regular partners and occasional partners ("hit and runs"). In the long run, they want to become successful husbands and fathers who have a nice house and perfect family, but they are **"not ready".** Despite their drive to not use condoms, they fear unplanned pregnancy and how it could affect their chances of achieving financial success (and resulting social status and recognition). Some say for these reasons (and not necessarily STIs), they would agree to use a condom, but it is unclear who is supposed to bring up condoms, since **pregnancy prevention is seen as a woman's job**.

- Secondary drivers**: Control, recognition, achievement**

3. Married or co-habiting young adults, 18-24 years

- Women
  - **Family values**: Young married women identify strongly as wives and mothers, and have invested in ensuring their family has the **image of the "good family"** according to their community's standards, even when things are far from perfect behind the scenes. They say their **identity and value is about being a mother**. They are very concerned with projecting an image of a happy family and see themselves in a **peacekeeper role**: they want to avoid conflict with their partner to prevent violence/abandonment, to **give their children a "normal" environment**, and to **avoid being judged** by their community. In the backs of their minds, these young wives worry that their husbands are not reliable and may leave them or may not provide enough financial support to give their children enough food, medical care, or education. For this reason, they are also hoping to do something "for themselves", such as business, but in the meantime, they feel they must do whatever they can to keep their husband happy. These young women also rely on friends for advice about family planning, but have doubts about their friends' intentions and fear to let others know if there is any disagreement in her marriage.
  - Secondary drivers: **Independence/control, status, nurturing**
- Men
  - **Status**: Young men carry their anxiety over being perceived as a real man into their marriages, and feel they need to establish themselves as a father and husband according to social norms. They describe dominating all household decisions—including family planning—and using violence or threat of abandonment to enforce their will. Part of establishing themselves as successful men includes having children and proving they can provide for children; in some cases, **having many children indicates financial success and stability.** Men in this group used phrases such as "children are the pride of men" and spoke of how their parents, in laws, and communities would have **no respect for them if they did not have a child within a year of marriage**.
  - Secondary drivers: **Control, achievement, recognition**

4. Post-partum women, including those with only one child and those with 3 or more children
    - **Family values**: First time mothers and mothers of three or more children generally mirror young married women ages 18-24—most were in this age range or just slightly older. Mothers described the importance of their **identify as wives and mothers** and internalization of the peacekeeper role. While they want to have a good life and financial stability to ensure a good environment for their children, **infertility (or perceived desire to end childbearing) is extremely taboo** and they fear what their husband or community would think if they were to stop bearing children or use a method to space their pregnancies. **These women are conflicted, however**; on one hand, they see how spacing or even limiting can improve their family and the family's image, however, they are still constrained by their husbands' dominance and the need to **assuage his ego and avoid rocking the boat.** Many say their husband married them for only one purpose: childbearing. For those who are married or cohabiting, they also **worry that their husbands are not reliable and may leave them or may not provide enough financial support to give their children enough food, medical care, or education**; for some mothers, this situation is their reality and they struggle to find resources or are forced to rely on their parents. They fear that their husbands will lose interest in them for many reasons: if they are too busy with children to show him attention; if they lose their looks; if they propose using FP.
    - Secondary drivers: **Independence/control, status, nurturing**

5. Facility-based health workers
    - **Recognition**: Health workers say they are working hard to make a difference in their communities and for Tanzania, even under extreme resource constraints. **It pains them that patients think they are intentionally providing poor services**, and **they resent that the government does not adequately remunerate them** in terms of salary, benefits, training, and other allowances. **They are embarrassed** that even though they work hard and have salaried, government jobs, they still do not have nice things and they struggle to give their families and children the "good life". They are overworked and don't have time to give their best to their clients or to give their best to their own "development activities" (side businesses). In every group they discuss these challenges in terms of being de-motivated; some mention nepotism in training opportunities and say things such as "if those people are getting the training, let them do all the work." Likewise, they describe little motivation to work beyond the bare minimum hours when they do not receive overtime pay and the clients do not appreciate their sacrifice.
    - Secondary drivers**: Status, poverty of time**

Why should I believe you?

This activity provided insights into the credibility of different message providers.

Health Facilities & Health Workers

Most people trust health workers' advice when it comes to family planning, but many are still reluctant to seek services from them or visit facilities

- Adolescent boys and girls are **intimidated by adult health workers**; they think they will be lectured, interrogated, and embarrassed, and possibly denied services. Both face **restrictive gender norms** (boys/men do not go for FP; girls do not have sex). They fear being seen at the facility by community members. Those who are out of school fear the doctor will use technical terms they do not understand, but they will not have the confidence to ask questions.
- Most young women, especially those who are married, do not face barriers to go to the health facility, especially if they have children, but they worry that they will be forced to sit through long counseling and the provider may not give them the method they have already decided they want. **Their biggest constraint is their male partner, who they think cannot support FP**. Even though they trust health workers, they have **fears about side effects** from modern methods and **do not want to jeopardize their fertility**.
- Post-partum women regularly access health facilities with their young children. Most trust health providers as sources of information about health and **believe providers can "test their bodies" to find out the right method for them**. However, they **continue to have fears of side effects** from hormonal methods and are co**nstrained by their male partners' objections** to FP
- Men 18-24 **believe it is completely unacceptable for them to seek information from a health facility about FP**. They object to modern methods and it is not manly for men to go to facilities or be involved in pregnancy prevention.

Close Friends

Friends and peers are a top source of "information" for both unmarried adolescents and youth, and for young married women

- Friends gossip about sexual relationships and condoms, reinforcing norms of when to use condoms and when not to
- Younger boys and girls say they rely on older friends to get condoms for them, but these friends do not tell them how to actually use them
- Women 18-24 rely on their friends' judgement when it comes to what methods to use. Their friends are "like them" in body and age, so if it works for their friend, it should work for them

Pharmacists/shop keepers

- Shops and pharmacies are mentioned as places where one can go to buy condoms, but young people have trepidation about doing so, both because they do not want to be seen by community members and because they don't want to face judgement or interrogation from

adult shop keepers. For those who do get condoms, they say the shop keeper just hands them over with no explanation of how to use them

- Young women ages 18-24 talk about getting methods from pharmacies, such as injections, pills, condoms, and emergency contraception (only mentioned in one group). They typically say this is where they come for methods they have decided to use based on their friends' recommendations. They like that they can go in and get whatever method they want, but the pharmacist does not tell them what to expect or specifics of how to use the method. There was some concern from the MOH liaison about pharmacists dispensing emergency contraception, as guidelines in Tanzania say this is only available for rape victims due to risk of side effects.

Traditional healers

- Every group discussed that traditional methods and healers are available in their society. While some told horror stories about bad outcomes (particularly permanent infertility), others were open to them (especially men). Women said their older relatives and some friends recommended their use ("I used it and nothing bad happened"). Some women admit to using both a traditional method and a modern method to hedge their bets.

Internet/mobile phones

- Girls in towns who have phones mention looking up information on pregnancy and condoms online. They have doubts about what sites are reliable, though. However, this is not accessible for girls who do not have phones or cannot read.

Schools

- In-school boys and girls demonstrated knowledge of technical terms and facts when it comes to condom use; it seems they have learned this information in secondary school. However, they describe that they know terms, but do not practice how to actually use condoms and are not provided with condoms

Religious leaders

- Participants generally did not talk about one on one interactions with religious leaders, but they discussed that their churches disapproved of modern methods, including Christians in Geita and Muslims in Mara.

Not mentioned, but potentially important

- Parents and other family members: Adolescents focused on their parents' disapproval of sexual relationships. They are strong influencers on youth, but none discussed getting information about condoms or pregnancy prevention from their parents. A few boys mentioned getting condoms from older brothers, but siblings were generally not mentioned.

- Mass media: Radio, television, and other media were generally not mentioned by participants as far as where they get information. **Some youth spoke of how advertisements they see show older men and women who are "not like them", which may potentially reinforce the idea that methods are for married couples**. Many participants could not read or write, which may also undermine the usefulness of written materials, and underscores the need for **all forms of communication to be adapted for low literacy groups**.
- Community leaders
- Celebrities

How will taking action solve a problem in my life?

People only change when they feel the change will solve a problem in their lives. Based on the audience insight findings, these are potential ways in which targeted changes can solve a problem in the lives of target audiences.

Adolescents and youth 15-17 years

When adolescents and youth make the targeted changes, they will feel they are:

- Securing their own future and ensuring their opportunity to build the life and family they want
- Recognized by their parents and community as a success and a source of pride

Women 18-24 (married and unmarried); Post-partum women

When women make the targeted changes, they will feel they are:

- Recognized by the community and identified as someone who has the good life
- Nurturing their child by protecting and insuring their future success
- Creating a stable future for themselves and their child

Men 18-24 (married and unmarried)

When men make the targeted changes, they will feel they are:

- Ensuring their family is financially secure and provided for
- Involved in decisions about the family's well being
- Recognized by the community and identified as someone who has made something for himself

Facility-based health workers

When facility-based health workers make the targeted changes, they will feel they are:

- Recognized, honored, respected, and celebrated by the community for the way they changed lives of those in the community.

Barriers to change

There are always barriers to change. Knowing what barriers exist is important information for effective messages. This consultation identified many barriers for adolescents and young people, post-partum women, and health workers.

Gender norms present a tremendous barrier to use of modern methods, including condoms for adolescents and unmarried youth, and other modern methods for spacing and limiting pregnancies.

- While adolescents seek to delay pregnancy, adolescent girls fear to be seen accessing condoms or other methods because they may not seem like a good girl. They see FP as something for older women, not girls like themselves. They feel boys and partners are the ones who make decisions about condom use. Adolescent boys think condoms are not cool and are not appropriate for men, based on what they have heard from friends. They have nowhere to go for reliable information. Most do not bring up risks of STIs. They cannot talk to parents, providers, or other adults because they might be seen as amoral.
- Young women dream of a good life, but fear their opportunities are limited once they have a baby and get married. They transfer their hopes and dreams to being the perfect wife and mother according to society's standards, which is linked to their fertility. Wanting to delay pregnancy once you are married, or to stop childbearing permanently, is seen as unnatural, Husbands have the perception that modern family planning methods are the equivalent of ending childbearing, which they take as rejection. Unmarried women have doubts about using modern methods other than condoms before marriage, and bring up the question of "WHAT IF it caused her to be permanently infertile?".
- Young men internalize gender norms of being an authoritarian figure within the home, being virile, and being capable of providing for their families. As their economic opportunities are limited, they use violence and dominance over their wives and large family size to prove they are a real man and husband. They want to be in control of decisions, but they feel women are the ones who have all the knowledge about modern methods, so they are threatened by her knowledge. They fear being seen as emasculated if their wife uses FP secretly, as this may mean she has other lovers, is prostituting, or generally does not respect his decisions. They see modern FP methods as the equivalent of ending childbearing, and a woman who does not want to bear his children anymore is rejecting him.
- Health workers have reservations about providing FP counseling to adolescent clients, especially girls. They mention the **fear that they are "green lighting" her to have sex and that there may be side effects of the methods that could jeopardize her future fertility**.

Injections, pills, and implants were the most common methods mentioned by participants. Perceived side effects of modern methods were often described, although some women believed that health providers could examine you or test your blood to determine which method is right for you. People often talked about side effects of FP generally, rather than side effects of specific methods. Examples of side effects included: causing women to become infertile (hormonal methods); heavy bleeding

(hormonal methods); enlarged heart and subsequent high blood pressure (injections); cervix becoming "loose" (pills); growing roots in your body like a tree (implant); cancer (condoms and hormonal methods). Some mentioned that condoms cause men to lose muscles in their penis (impotence?) and that it could burst inside a woman's vagina and need to be surgically removed. Respondents also mentioned using the calendar method, withdrawal, or trying to clean out semen from the vagina after sex to prevent pregnancy. Fear of infertility was a major barrier to method use, especially by girls and women who do not yet have children or have not reached their desired number of children. In one site women who had just had their first birth described that they did not want to space their pregnancies using modern methods, as they would rather get it "out of the way" and not take risks.

Participants also brought up traditional methods and healers in nearly every group. While participants were divided on whether they trusted these kinds of methods, it is clear **the services are widely available and some in the community are using them**. Participants told many stories of young women being bewitched and suffering infertility. Others described that the methods simply don't work and women find themselves pregnant. Others see these methods as having lower risks of side effects than modern methods, and talk about how their mothers and grandmothers used them with no problem.

Health workers represent a significant barrier for adolescents and some unmarried women, as they fear being judged for being sexually active before marriage. Healthcare seeking in general is a barrier for young men, although this is not necessarily due to characteristics or behaviors of the workers themselves. Most participants said they trusted health workers when it came to information about FP, although young people in particular **feared they would use technical terms they did not understand, but they would fear to ask questions because it would prolong the visit, and they would be embarrassed to talk about issues of sexuality in detail.**

Some young women are seeking methods from pharmacies (*duka la dawa*) rather than health facilities. They take their friends' advice on which methods to use and are not adequately counseled on side effects and the range of options. Pharmacists provide the methods without any further advice. There are potential quality control issues, also, as some may be providing emergency contraception that is no longer legal to sell or worries of counterfeit products.

Health workers identified many barriers to providing the type of services people would like to receive, especially in Mara region:

- Time pressures (they must get up early, travel by bike to work, they are physically exhausted when they get there, they do not have enough time per client, they have no time for their own families and lives)
- Lack of training and professional development opportunities (they are passed over for training in favor of higher profile staff—even though they are the ones providing FP services)

- Lack of compensation, training opportunities, and appreciation from their patients undermines their motivation

Next Steps

Based on these audience insights, creative briefs will be developed, which the project will use to inform development of FP messages, SBCC tools, and materials to be used in targeted and integrated SBCC.