
Sex, choice and control: the reality of family planning for women and girls today



Judith Atieno Basil, 25, from Kisumu in Kenya, is secretary of the Ulusi Youth Group supported by ActionAid where she raises awareness of early pregnancy, domestic violence, human rights, and safer sex including condom use.

PHOTO: SVEN TORFINN/PANOS PICTURES/
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Executive summary

Reproductive choice and women's empowerment

“Before ActionAid came into the community we didn't talk back to the men, but things have changed a bit. Some men are now listening to their wives and women have increased confidence to speak out in public... However, men are still making decisions about having children... We need to have a programme for men to understand the need for family planning and stop making women have so many children.”

Evelyn Flomo, Liberia

“I refused to have sex and he slept with me. I got pregnant yet my child was only eight months old. He refused and forced me. In order to avoid quarrels and shame I just agreed.”

Hadia Makame, Tanzania

“Empowering women to take decisions about their own future is the right thing to do for so many, many reasons. Not least... the fact that it is a basic human right.”

Andrew Mitchell, Secretary of State for International Development, 2010

To choose when and whether she has children is a fundamental right belonging to all the world's women. Despite this, even conservative estimates acknowledge that at least 200 million women are denied this right and do not currently have access to the family planning information and services they want and need.¹

The UK government has rightly taken a stand, recognising that women's ability to control when and whether they have children is fundamental to the achievement of all the Millennium Development Goals (MDGs), particularly those on promoting gender equality and empowering women, reducing child mortality and improving maternal health.

The government's current approach concentrates on the provisions gap: seeking to improve the supply of contraceptives in developing countries and to reduce their cost. This work is critical; as is making sure that women and girls are able to choose from a range of contraceptive options that best meet their particular needs. That said, improving supply is only one of the issues that will need to be addressed if the goal of universal access to contraception is to be realised. Many women and girls, even where contraceptives are available, will be prevented from accessing or using them by a myriad of social barriers caused by gender inequality. These include:

A lack of services that cater to women and girls' needs: the attitudes and prejudices of service providers may hinder certain groups of women and girls from fully accessing services, including those who are unmarried, adolescent, disabled or living with HIV. Providers may provide partial or misleading information to direct the choices of women and girls according to their own perception of the appropriateness of certain methods.

A lack of decision making power: violence prevents women and girls from refusing sex and negotiating contraceptive use, and many women and girls' sexual experiences are forced and unwanted. Often there is an expectation that husbands make decisions about family size and can compel their wives to have unsafe sex. Fear of violent reprisals can prevent women and girls from attempting to raise contraception with their partners or attempting to use it without their knowledge.

Difficulties in accessing contraception: women and girls may need permission from their husband or family to travel outside the home or community to visit a health clinic and may not have money at their disposal to pay for services or supplies, or for transport. For unmarried women and girls, the stigma associated with being seen at a clinic can prevent them attending at all.

For these reasons, approaches to family planning that focus solely on supply are destined to fail. Family planning interventions need to tackle gender inequality, combat violence and promote women's rights if they are to have substantial and sustainable impact. We must ensure that women and girls have real access to contraception, exercising free choice over the methods they use and when they use them without fear of reprisal.

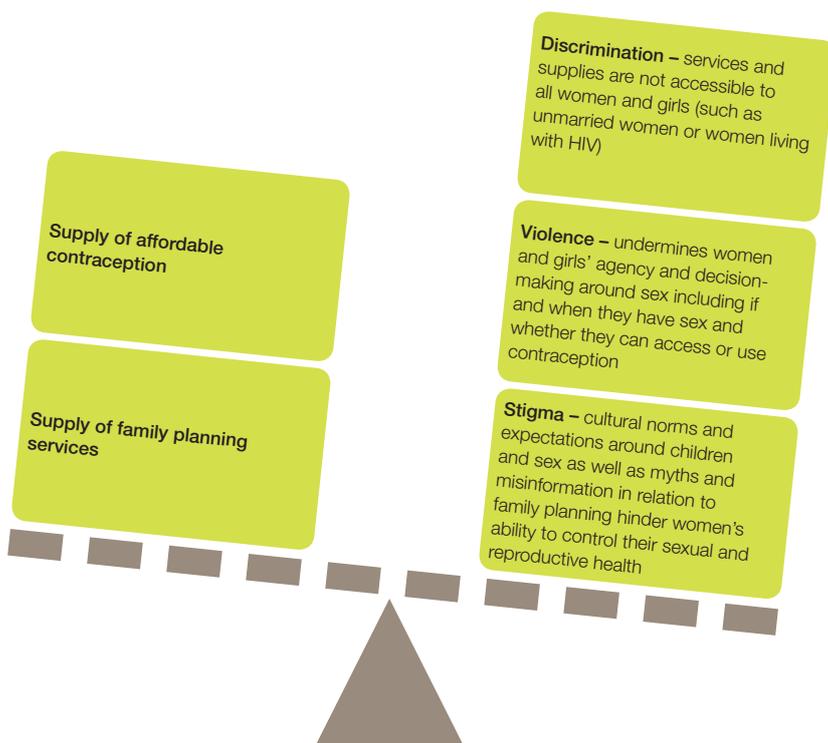
This report tells the stories of four women and girls that ActionAid works with in sub-Saharan Africa (Uganda, Liberia and Tanzania) who have been denied choice over their reproductive lives. Their experiences highlight some of the key barriers to increasing access to family planning that affect real women and girls' everyday experiences – and how important the power dynamics between women and men are when it comes to making sexual and reproductive choices.

The stories demonstrate why interventions that empower women and girls to negotiate the terms of their sexual relationships are so desperately needed. The UK government and its partners could radically progress this agenda by:

- 1. Promoting choice:** ensuring the fundamental aim of their approach is to support women's right to choose whether and when to have children.
- 2. Financing women's rights:** ensuring funding is available to further the empowerment of women and girls.
- 3. Promoting national change:** ensuring national legal and policy changes that promote women's rights.
- 4. Strengthening national health systems:** ensuring adequate investments so they can better deliver family planning services to more women and girls.
- 5. Recognising the needs of all women and girls:** ensuring the rights of all women and girls to access family planning are met regardless of age, race, ethnicity, caste, language, disability and marital or HIV status.

The Department for International Development (DFID) has already committed in its Business Plan to “empower girls and women so that their lives are significantly improved and sustainably transformed through better education, greater choice on family planning and preventing violence against them.”² DFID's work on violence against women has already led to significant change, including new laws to protect women from domestic violence and harmful traditional practices, a bolstering of women's participation in peace building and addressing violence in conflict, and the creation of support services and refuges for women at risk of violence. We urge the UK government to build on this and commit to women's empowerment as the fundamental goal of its family planning efforts.

Why supply is not enough – barriers to access and use



Introduction

Why reproductive choice is important

Every day, all around the world, millions of women and girls find themselves unable to make one of the most important and basic decisions about their lives: whether and when to have children. For those in developing countries, this challenge is often especially stark – at least 200 million women do not have access to the information and services they need to help them delay or space the number of children they have.³ This figure, known as the ‘unmet need’, is a conservative estimate; it accounts only for those women and girls who are “married or in a union” (ie, a recognised relationship).⁴ In reality many more women and girls need access to family planning services. More worryingly, the problem is getting worse. The number of women needing these services is expected to increase by at least 40% in the next 15 years.⁵

Eight million of the approximately 210 million pregnancies across the world every year face life-threatening complications.⁶ And 99% of the 536,000 women who annually die in pregnancy and childbirth live in developing countries.⁷

In recognition of how important reproductive choice is, women and girls’ fundamental right to decide both whether they have children, and to plan when they have them have been enshrined in a number of international agreements, including:

- + the Programme of Action of the International Conference on Population and Development (ICPD) (1994)⁸
- + the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) (1979)⁹
- + the Platform for Action of the Fourth World Conference on Women (1995)¹⁰
- + the recent landmark resolution at the 45th Session of the United Nations Commission on Population and Development (CPD) in April¹¹

Evidence has shown how important women’s rights are to achieving other development ambitions such as the MDGs,¹² and access to family planning has been particularly highlighted as being critical to achieving the MDGs.¹³

Why women don’t currently have reproductive choice

There are two sets of reasons why so many women and girls in developing countries cannot make choices about their reproductive lives. Both sides of this coin are important. On the one hand, weak or poorly-stocked national health systems mean that in many places there simply aren’t enough service providers or supplies to meet demand. On the other, gender inequality and unequal power relations between women and men mean women and girls are often not able to decide whether or when they have sex, or under what conditions they have it, including whether or not they use any form of contraception.

The UK government has recently made it a priority to help women and girls have more choice and control over these basic decisions. Working with partners such as the Bill & Melinda Gates Foundation, the government is trying to encourage the international community to pay much more attention to the importance of family planning. ActionAid warmly welcomes this effort. Women’s lack of reproductive choice is a global challenge that urgently needs addressing.

Unfortunately, most international efforts so far have concentrated on only one side of the coin – supplying the contraceptives – without addressing the flip side of the problem: tackling the barriers that stop women from being able to use them. Yet women and girls’ lack of power in relationships is one of the main reasons why they cannot decide what happens in their reproductive lives.

How violence against women undermines reproductive choice

Violence against women and girls is a particular block to women and girls being able to make choices about their sexual and reproductive health. It is a widespread problem: at least one in three women experiences violence in her lifetime.¹⁴ Forced and coercive sex, including rape, is common; millions of women and girls are compelled to have sex with men through social, psychological, physical or financial pressure, and have little negotiating power to influence the terms of these engagements. Marital violence against women, according to national health surveys around the world, is prevalent. Indeed, many people still believe that husbands are entitled to have sex with their wives even if women don’t want to. More than 2.6 billion women live in countries where marital rape is still not illegal.¹⁵

Lack of power is a feature of many women and girls’ sexual experiences throughout their lives and can

begin very early on. In a detailed study, the World Health Organization (WHO) found that more than 14% of women reported their first experience of sexual intercourse as forced in Bangladesh, Ethiopia, Peru and Tanzania.¹⁶ In fact, the younger a girl is when she first has sex, the more likely it is that she was forced: over 35% of women in Bangladesh (36-38%), Peru (41-45%) and Tanzania (40-43%) who were under the age of 15 when they first had sex were forced.¹⁷

Aishatsu Kamara,

21, was looked after by her mother Mary, an ActionAid-trained traditional birth attendant, during her pregnancy.

PHOTO: JENNY MATTHEWS/ACTIONAID



Girls who are married before they are 18, a common practice in sub-Saharan Africa and south Asia, are at a particularly high risk of violence. Work by the UN found that a significant number of the estimated 82 million girls who are married face high risks of violence – including rape – from their partners.¹⁸ Importantly, UNICEF has found that girls are more likely to be married before they are 18 if they are living in poverty or have lower levels of education.

Girls who are married early lack bargaining power in their relationships, especially when they are poor or uneducated or are much younger than their male partners. This means they generally do not have the power to refuse sex or negotiate condom use, cannot access or pay for health services without permission, and are often pressured into having children by their husbands or families, sometimes through physical and sexual violence.¹⁹ This lack of bargaining power at the start of a marriage can set the pattern for the rest of a woman's life; she may never be able to influence decisions within the home or relationship, including whether to use contraception.

What this report shows us

This report tells the stories of four women and girls that ActionAid works with in sub-Saharan Africa (Uganda, Liberia and Tanzania) who have not been able to make choices about whether and when to have children. By hearing about the real-life experiences of Donnah, Evelyn, Janneh and Hadia, we learn what some of the key barriers to increasing women and girls' access to family planning actually look like in real life – and how important the power dynamics between women and men are when it comes to making sexual and reproductive choices. And through the voices of these four women, it becomes clear why international efforts on family planning, if they are truly to help women and girls, must address both sides of the coin.

Donnah's story

Donnah Nnassuna,
16, with her daughter in
Kalangala, Uganda.

PHOTO: CHARLES KIYINGI/ACTIONAID



Donnah Nnassuna is 16, unmarried, and lives in Kalangala, Uganda, a remote island community made up of 84 islands scattered across Lake Victoria. Kalangala faces many unique challenges due to remoteness and scattered geography, including lack of access to schooling and health services.

Donnah was attending secondary school when she became pregnant last year. Her child is now four months old. In Buganda culture, being an unmarried mother is seen as bringing shame on the family and pregnant girls are not permitted to live with their parents as part of cultural 'cleansing practices'. When Donnah's family discovered she was pregnant, she was banished from her home and lived with her grandfather and later her aunt. Donnah was isolated by her community and the stigma led to ill health and lack of support throughout her pregnancy.

Before she became pregnant, Donnah had not thought about family planning or worried about becoming pregnant:

"At school I was informed that family planning is the prevention of having children through sex using condoms, intra uterine devices and injections. However, this seemed to contradict what the elderly women told us and what the older girls said about family planning... I was told that injections interfere with monthly periods and that the woman leaks all the

time, that pills suck blood out of the person so that they... eventually die... and that condoms get stuck inside after sex and the only remedy is surgery."

Donnah also describes how she knows of women and girls in her community trying to abort their babies rather than seeking help: "They use local poisonous herbs and overdose on chemical pills."

Currently, she is abstaining from sexual intercourse: "I don't wish to have more children especially in my current state. I am intending to concentrate on my studies and look after my baby. I don't want to annoy my father again."

Donnah would like to use contraception but she is unsure of the effectiveness and side effects. It is difficult for women to access information about family planning in Kalangala. For a population of 650,000, services such as ante- and postnatal care and family planning are provided by 11 health centres spread across 62 islands. It is expensive to move from one island to another due to the cost of boat fuel, and unpredictable weather makes the use of canoes dangerous. Technology such as telephone, email and radio have only recently come to Kalangala, and remain prohibitively expensive for most people.

Bumangi is fortunate to have a health centre run by the Catholic Mission. However, as Donnah explains, because she is unmarried, it is still not easy for her to

Lessons for policy makers

Donnah's experiences remind us that unmarried girls and women have sex, sometimes when they do not want to. They need access to appropriate, affordable and high quality family planning services and information, just as married women and girls do. Younger women and girls have a particular need for comprehensive sex education to help them negotiate their sexual relationships from an informed position, and to dispel myths. This can also help them to build more equitable relationships, which are essential to exercising sexual and reproductive choice.

Motherhood is an important role that many women would like to play. However women and girls need to be able to make choices about how they take it on, including when. In addition, motherhood is not for everyone and should neither be forced nor be the only basis on which women and girls are entitled to enjoy good sexual and reproductive health. Girls and young women need access to accurate and high quality information and counselling about family planning and their sexual and reproductive health before and regardless of whether they plan to have children.

access information: "Married women qualify to have sex and therefore can ask related questions, while for unmarried women this [asking about family planning] can be taken for immorality and promiscuity."

Consequently, Donnah describes how information in relation to sexual and reproductive health tends to come from elderly women or older girls. This makes it difficult for young women to know the real facts around family planning.

Donnah does not feel she, or many other women in her community, can control when they have sex or how many children they have. "Women have to be careful when making decisions in this area. It is sensitive, and preferably should not be discussed at all. If a woman dissatisfies her husband by refusing to have sex this usually results in sex outside marriage, forced sex and domestic violence."

Donnah received support, including counselling, after her family abandoned her from a local women's rights organisation called KAWID, an ActionAid Uganda partner. This support helped her gain the courage to rejoin and attend school after giving birth, a significant achievement and one not always common amongst her peers.

- + Contraceptive use²⁰ in Uganda is 24%. The unmet need for family planning is 41%.²¹
- + Almost a quarter of unmarried girls age 12-19 report being coerced in their first sexual experience.²²
- + Abortion is permitted in Uganda under certain circumstances, including to save a life and in cases of sexual violence.²³
- + Girls are legally allowed to be married at age 16 with parental consent.²⁴
- + More than half of women aged 20-49 report being married by the time they are 18, almost 16% by the time they are 15.²⁵
- + More than two-thirds of women who have ever been married report they have experienced violence from their husbands or other intimate partner.²⁶

Evelyn's story

Evelyn Flomo, 32, a community activist in her village in Grand Gedeh County, Liberia.

PHOTO: ACTIONAID



Evelyn Flomo is a farmer from Grand Gedeh county in Liberia. She is 32 years old and married with one child.

When Evelyn was growing up she decided she would like to have only two children. However, her husband had plans for a large family: "When we got together he told me he wanted 10 children. I also told him my plan but he said he is the man and his decision is what we will go by. I discussed it with him because I had my plans and having too many children can make women fall behind. When you have many children you have to spend more time working hard to support the children; you can't spend time with your friends. If I had many children I would not be able to help women resolve their problems and participate in community work... The men leave all the burden on us yet they want plenty of children."

Evelyn was married when she was only 15, and this affected her ability to make decisions in her marriage. "When we first got together, I suffered a lot because I didn't have much idea about life. Anything he said I would do even if I didn't want to. I would do all the work in the house and most of the work on the farm and he controlled my movements. At times he locked me up in the house and would go out for the whole day. He changed a bit after he beat me and I miscarried twice. The doctors told him to allow me rest. The presence of the ActionAid Access to Justice project [which Evelyn is a part of] also helped to

change the situation as it helped me to build my confidence and made me aware of my rights."

However, as Evelyn explains, it is still difficult for her to make decisions about if, and when, she has sexual intercourse with her husband. "Our men are still making the decisions. Most of the time when we refuse they can force us and it can be hard for us to report. My husband can force me to have sex even when I am sick and sometimes when my menses are flowing."

Evelyn, like other women in her community, had little access to information about family planning and was afraid of using contraception. During ActionAid training she learnt about contraception and decided she wanted to use it. However, accessing contraception was not easy, particularly as her husband refused to allow her to use family planning.

"There is only one place and it is the hospital which is so far away, and you have to pay transport costs to get there. Even at the hospital there are not many nurses and they are sometimes unavailable... The nurses demand us to bring our husbands before attending to us. I secretly talked to a nurse and she provides treatment from her house. I started with the pill but it was difficult because I had to take it without my husband knowing. I had to keep the pill at my friend's place and go there every day to take it. When

Lessons for policy makers

Evelyn's experience shows us that women and girls cannot always control whether, when or under what circumstances they have sex. They therefore need access to family planning services that are sensitive to their needs, such as contraception that does not require their husbands' consent and can be kept private. Service providers also need to be trained in women's rights, and encouraged to support women and girls to take control of their own sexual and reproductive health.

Supplies and services need to be affordable or free so that women and girls can access them despite lack of income, especially where they do not have independent means. Supplies that are women-controlled, such as female condoms, can be much more helpful than traditional male condoms that require negotiation with male partners.

Specific support for women's empowerment is clearly needed. Given the widespread nature of violence against women and girls, programmes that directly tackle violence are essential. Programmes that build everyone's awareness of women's rights and support women and girls to claim these rights, for example by ensuring they are able to speak out about problems, are vital. Aid can play a crucial role in making this happen.

he noticed he left me. I begged and managed to convince him to return. I stopped the pills and took the injection but it did not make me feel well, so then I tried an implant. We are together now but I am worried about when he finds out."

Evelyn is concerned that not many women can access contraception in her community. She also describes how many unsafe abortions are happening. "Young girls can't go to the hospital because they don't have money and are afraid of the stigma. Most use the traditional way to remove a pregnancy and sometimes they die in the process."

Change is happening, but it is slow. "Before ActionAid came into the community we didn't talk back to the men but things have changed a bit. Some men are now listening to their wives and women have increased confidence to speak out in public... However, men are still making decisions about having children... We need to have a programme for men to understand the need for family planning and stop making women have so many children."

- + Contraceptive use in Liberia is 11%. The unmet need for family planning is 36%.²⁷
- + About 1 in 7 women who first had sex before they were 15 report the experience was forced.²⁸
- + Abortion is permitted in Liberia under certain circumstances, including to preserve a woman's mental health and in cases of rape and incest.²⁹
- + Liberia is in post-conflict transition, having witnessed unprecedented levels of sexual violence against women during its recent 15-year war.

Janneh's story

Janneh Alladin, 36, who helped form Liberia's only network of women living with HIV.

PHOTO: ACTIONAID



Janneh Alladin is 36 years old and lives in Monrovia, Liberia, with her husband and eight-year-old daughter. Janneh is living with HIV and was instrumental in the formation of the only network of women living with HIV in Liberia, the Liberian Women Empowerment Network (LIWEN), an ActionAid partner.

In 2006, Janneh visited the Planned Parenthood Association Clinic located in the centre of Monrovia. However, due to her positive HIV status, Janneh was told she did not need family planning: "When I got to the clinic, because I am HIV-positive, the feedback that I got from them made me feel very bad. It made me feel I was discriminated against. I wanted to be able to plan my family. They told me that because I was HIV-positive I might make an HIV-positive baby and so not to even think about having sex. But I have the right to access family planning. If my husband wants to have a child, I have the right to say I don't want a child now and to plan. But when I went there they turned me down."

Janneh decided to try again the following year. "When I went back she told me you cannot get family planning. You have one child and you should not even think about giving birth again. So I decided to complain to the centre supervisor. She said she would talk to the programme officer. She tried to discuss it and the programme officer got angry. They had a big argument and so I decided I should leave the office."

Due to the advocacy efforts of LIWEN and other like-minded organisations, attention was drawn to the practices of the clinic and staff changes were made. After these staff changes, Janneh decided to return for the third time. "Last year I decided to go back because they have changed most of the staff at the clinic... This time I didn't disclose my HIV status and they put me on the injection."

When Janneh was given the injection the possible side effects were not explained to her. And she was not given information on other forms of contraception so that she could make an informed choice about the method she wanted to use. After three months Janneh stopped menstruating. "I was worried and wanted to know what was happening but they didn't explain anything to me. I returned to the clinic and told them that I had stopped receiving [menstruating]. They said this was something which was expected with the injection. I couldn't understand why they didn't tell me this when they first gave me the injection. I told them I wanted to receive [menstruate] and they said if I stopped the injection then I would start receiving again."

Janneh stopped the injections and did not return to the clinic. "I didn't go back again because I felt they were not paying attention to me and giving the information that I needed. We need to be given information about the side effects of family planning and educated about it. When we have that knowledge then we can decide."

Lessons for policy makers

Janneh's experience highlights both how stigma can influence women and girls' access to family planning, and how family planning interventions can miss their targets because of assumptions based on stigma. Women and girls living with HIV have a right to and do have sex, sometimes when they do not want to. They also have a right to and do have children. Women and girls living with HIV therefore need access to non-discriminatory, appropriate, affordable and high quality family planning services. This includes accurate and non-biased information and support about different options and their side effects.

Women and girls living with HIV also need access to programmes that promote women's empowerment and gender equality, as evidence shows they are at high risk of experiencing gender-based violence. This violence reduces their ability to negotiate their sexual relationships, such as resisting unwanted sex or insisting on condom use. Family planning services that do not account for these circumstances will make themselves inaccessible and irrelevant to women and girls who are in clear need.

Although Janneh's husband wanted to have another child, he was supportive of her choice to use contraception. They have now decided to have more children, but Janneh's menstruation is yet to return. "My husband didn't have a problem with me using family planning. He is HIV negative. He said he can take care of me and he really wanted to have a child but I told him we should wait. But now we have decided to have a child and the problem is that I can't. Although I stopped the injection last year I still do not have my cycle."

Janneh believes information is crucial and explains that most of the people living with HIV that she works with do not know about family planning. "We should also educate the HIV community about family planning. Everyone should know about and be able to access family planning. Women should be told the side effects and the different forms of contraception so they can decide which one to take. Information should also be given to the men so they can understand and support their women."

- + Liberia's HIV prevalence rate for adults aged 15-49 is estimated at 1.5%.³⁰
- + Women account for 58% of all HIV-positive adults living with HIV.³¹ Violence against women is recognised as a driver of the epidemic in Liberia.³²
- + 10% of women report their first experience of sexual intercourse was forced.³³
- + Almost 45% of women aged 20-49 report being married by the time they are 18; over 14% by the time they are 15.³⁴
- + Just under half of women who have ever been married report they have experienced violence from their husbands or other intimate partner.³⁵

Hadia's story

Hadia Ali Makame,
46, community mobiliser in
Mkokotoni village, Zanzibar.

PHOTO: HALIMA LIBEMBE/ ACTIONAID



Hadia Ali Makame is 46 and lives in Mkokotoni village in Zanzibar, Tanzania. Hadia is married with eight children, and is a community mobiliser and advocate for women's rights in her village through the ActionAid Violence Against Women (VAW) project.

Hadia did not receive any information in school about family planning. "When I completed my studies I had never heard about family planning. I got this information after I got married and started attending the clinic... In the past family planning was not as open as it is now. Had I known earlier maybe I would have waited until my child was above one year old before I had the next one."

When Hadia was 20 she was forced by her parents to marry a man more than twice her age. "It greatly affected me. I was forcibly married. I was just taken to an old man who was 50 years old. I was not able to decide how many children I could have. I was afraid of him." She tried to discuss family planning with her husband. "I used to tell my husband, according to the age of the children, maybe we should not have another child until this child grows. But you know men do not accept this. Even if you tell them we should go to the hospital to seek advice; they do not accept it."

Hadia's eldest child is 25 and her youngest is now seven. Hadia does not want any more children as she

is worried she may not be able to provide for all of them. In her village there is a committee on gender-based violence and meetings are held to inform women about their sexual rights and reproductive health. Information is also available from the health clinic in the area.

Hadia went to a two-day class to learn about contraception and family planning, but she decided not to use contraception. "I did not like it. I have seen three women who had problems. One had an uncontrollable discharge of fluid, another had periods which were irregular and the other one got pregnant." Hadia has also heard of women who use unsafe methods of abortion such as using sticks, herbs, roots and other medicine.

Hadia has been trying to use the unreliable calendar method of family planning, which involves keeping track of her cycle to avoid intercourse on days when she may become pregnant. This has meant some of her children have reached the age of three before she has had another child. However, even this method causes conflict with her husband. Hadia explains how, when she has refused sex, her husband does not respect her decision. "I refused to have sex and he slept with me. I got pregnant yet my child was only eight months old. He refused and forced me. In order to avoid quarrels and shame I just agreed."

Lessons for policy makers

Hadia's experience demonstrates that the availability of family planning services alone does not guarantee that women and girls are able to access or receive accurate information about their options. There is a clear need for comprehensive sex education to dispel myths and ensure women and girls are reliably informed about all of their options and their side effects.

In addition, even where they are able to access the services, gender inequality means women and girls may not be able to exercise control or choice. The high rates of gender-based violence against women within marriages in Tanzania highlights particularly starkly the importance of delivering family planning services within a context of women's empowerment. Forced marriage and other forms of violence means many women and girls do not have the negotiating power they need to make choices about their reproductive lives.

Interventions that both strengthen national health systems to deliver better and more comprehensive services, and also deliberately empower women and girls and promote gender equality, are desperately needed. Adequate and appropriate financing can make the difference.

In her work with the community Hadia sees many problems that exist for women with large families: "The problem of men abandoning children exists in the community. You end up struggling. The husband may decide to go to the woman or [second] wife who does not have children so that he is not disturbed. The wife with many children is avoided by the husband and he evades his responsibilities. Women with many children are worried about being abandoned by the men."

However, Hadia has seen some change in her village: "Some men and women now use family planning. In the past men would not agree. Some women used it secretly so they could have a break. In the past we did not receive any information about family planning. You would be advised to count your days [safe and unsafe days of your cycle]. Some women did not even know about this method. When the government started providing family planning services people started to become aware of it."

However, Hadia believes that more guidance is needed about the different family planning methods from doctors: "Doctors should give more details and elaborate about the methods and usage, such as how to clean yourself, so that you do not have problems while using them."

- + Contraceptive use in Tanzania is 34%. The unmet need for family planning is 25%.³⁶
- + Over 10% of women aged 15-49 report their first experience of sexual intercourse was forced.³⁷
- + Abortion is permitted in Tanzania to save a woman's life.³⁸
- + Girls are legally allowed to marry at 14 with parental consent.³⁹
- + Almost 40% of women aged 20-49 report being married by the time they are 18, almost 8% by the time they are 15.⁴⁰
- + Half of women who have ever been married report they have experienced violence from their current or former husbands.⁴¹

Conclusion

How policy makers can increase reproductive choice

Millions of women and girls do not have access to the family planning services they want – and to which they have the right – and gaps in supplies and services desperately need to be addressed.⁴² The UK government's efforts to fill those gaps can make invaluable contributions to helping millions of women claim their right to decide when and whether they have children.

That said, civil society leaders, including ActionAid, have expressed concerns that by focusing only on supply side gaps, policy makers could inadvertently undermine the very gains they are working so hard to achieve. If women and girls living in poverty are to benefit, addressing the provisions gap needs to be done within the context of strengthening national health systems, and working towards universal and comprehensive access to sexual and reproductive health services.⁴³

Nevertheless, even the most perfectly stocked and strong national health system will only ever be part of the solution. The four stories in this report illustrate why providing affordable contraception removes only one barrier to women and girls having reproductive choice. Violence and the threat of violence, forced and early marriages, rape, including in times of conflict and within marriages, and coercion and abuse, all undermine women and girls' agency and decision-

making around sex. Even where contraception supplies exist, women and girls may not be able to access them because their mobility is deliberately restricted or controlled, or they may not be able to use them with partners where they have little negotiating power.

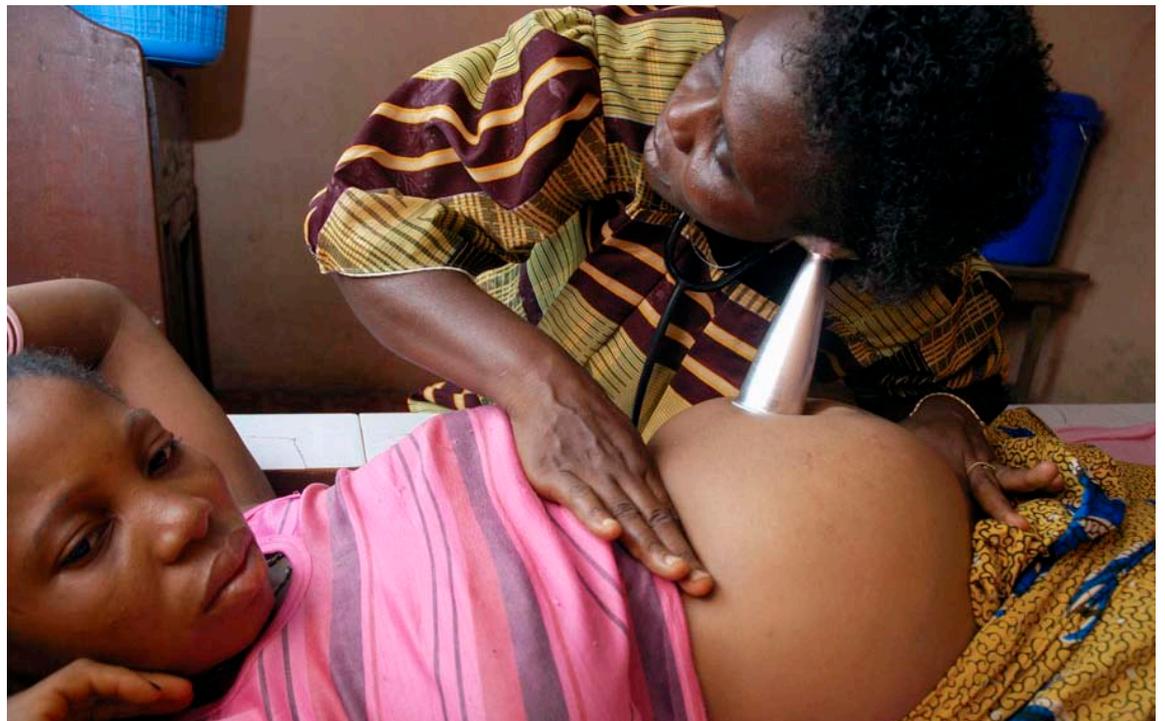
The UK government's priority focus on family planning has the potential to radically transform the lives of millions of women and girls around the world similar to Donnah, Evelyn, Janneh and Hadia – if it can address their full needs by tackling gender inequality and promoting women's rights.

As the case studies illustrate, steps such as building women and girls' negotiating power through access to accurate information and comprehensive sex education, providing women-controlled contraception such as contraceptive injections, making marital rape illegal, training service providers in women's rights, creating awareness about women's rights within communities, introducing and enforcing marriage minimum age laws that promote girls' rights, and providing non-discriminatory, youth-friendly sexual and reproductive health information services can all make an enormous difference.

Ultimately, the success of the UK government's efforts will be measured by whether women and girls' options genuinely increase, so that they are better able to make choices about their sexual and reproductive health and lives.

Mary Kamara, tending to a pregnant woman. Mary, 40, was trained by ActionAid to be a traditional birth attendant. She lives in Kola tree community.

PHOTO: JENNY MATTHEWS/ACTIONAID



Recommendations

Working with its partners, the UK government can ensure its interventions achieve real change by:

Promoting choice: ensuring the fundamental aim of family planning efforts is to support a woman's right to choose whether and when to have children as part of a drive towards delivering comprehensive sexual and reproductive rights for all women. Decisions on whether to or not to have children must be taken by women themselves and steps must be taken to expand the information and choice of methods available to women and girls in order to ensure those decisions are fully informed.

Financing women's rights: ensuring the empowerment of women and girls is financed as a core element of family planning interventions. This means deliberately increasing access to family planning services in ways that promote the empowerment of women and girls, such as training health care providers on women's rights and providing women-controlled contraceptive options, as well as implementing specific programmes designed to promote gender equality and reduce violence against women and girls.

Promoting national change: ensuring policy makers commit to bring about national legal and policy changes that promote women's rights and lead to better family planning outcomes. Specific commitments are required to eradicate the discrimination, gender inequality and violence against women and girls that affect women and girls' access to sexual and reproductive health services and rights, such as enforcing marriage minimum age laws, criminalising marital rape, and providing universal and comprehensive sex education.

Strengthening national health systems: ensuring adequate investments into national health systems so they can deliver better services to more people. Family planning objectives must be integrated into efforts to strengthen national health systems so they are accountable and can deliver appropriate, affordable and higher quality services to all women and girls, including services that are free at point of delivery.

Recognising the needs of all women and girls: ensuring the rights of all women and girls to access family planning are met and respected. Women and girls who are unmarried and not in relationships, women and girls living with HIV, and women and girls who have no plans to have children or sex with men also need and have a right to accessible, affordable, high quality family planning services and information – not least because sex is sometimes forced – and this ambition must be integrated into agreed plans and budgets.

Endnotes

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