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Maternal and Child Survival Program

Postpartum Family Planning in Ethiopia
Provider Perspectives on Male Engagement

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Background

Worldwide, there is growing recognition of the postpartum period as a critical window of opportunity to prevent closely spaced and unintented pregnancies. The World Health Organization (WHO) recommends an interpregnancy interval of at least 24 months before attempting the next pregnancy to reduce the risk of adverse maternal, neonatal, infant, and child health outcomes, including miscarriages and stillbirths, preterm and low weight newborns, malnourished and stunted children, and maternal and child mortality (WHO, 2006; Baqui 2018). Despite this evidence, unmet need for family planning (FP) is among the highest for postpartum women and short birth intervals continue to account for high maternal and child morbidity and mortality rates in low- and middle-income countries, including Ethiopia (Tran 2018; Pleah 2016; Moore 2015, WHO 2013).

Box 1. What is postpartum family planning?

Postpartum family planning (PPFP) is defined as "the prevention of unintended and closely spaced pregnancies through the first 12 months following childbirth" (WHO 2013).

Demographic and Health Survey (DHS) analyses from 21 countries found that, in 9 countries, 50% of non-first births occurred at intervals considered too short (Moore 2015). Although knowledge of at least one contraceptive method is nearly universal in Ethiopia, contraceptive prevalence rate is a modest 36%, and 74% of women 0-23 months postpartum have unmet need for FP (EDHS 2016; Moore 2015).

Women eligible to use FP methods encounter several barriers including low perceived risk of pregnancy, perceived fear or actual experience of side effects, spousal disapproval or lack of male engagement, religious prohibition, and inadequate access to information and a range of contraceptive methods (Tran 2018, Ghule 2015; Kibira 2015; Withers 2015; Sedgh 2014; USAID PPFP 2014, Mekonnen 2011). Growing evidence from developing countries indicates that gender norms have a profound influence on women's reproductive decision-making and contraceptive use. Similarly, in Ethiopia, male partner's opposition to FP and fear of spousal resistance have been cited as considerable obstacles to women's uptake and continued use of FP methods in Ethiopia (Alvergne 2017; Atnafe 2016). In fact, findings suggest that contraceptive uptake is almost 3 times higher among women whose partners support the use of FP methods (Mekonnen 2011; Mohammed 2014).

Box 2. Purpose of the Brief

This brief presents a secondary analysis of a PPFP study in Ethiopia, which included qualitative interviews with health care workers and health officials, so as to explore provider perspectives on:

a. male influence on women's PPFP uptake
b. existing male engagement initiatives across different levels of the health system
c. barriers to constructive male involvement in PPFP.

Methodology

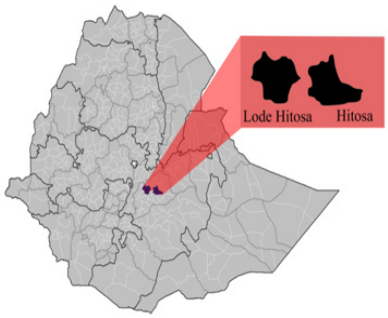

Figure 1. Study location

In 2015, USAID's Maternal and Child Survival Program (MCSP) worked collaboratively with the Ministry of Health (MOH) of Ethiopia to design and initiate a mixed-methods, quasi-experimental study on utilizing all health contacts to integrate PPFP. The study was conducted from early 2017 to 2019 in Hitosa and Lode Hitosa districts in Arsi Zone of Oromia region to assess the impact of integrated messaging, community-based interventions, and monitoring tools on PPFP uptake. For this study, MCSP intervened in all health centers of two woredas or districts and oriented health extention workers in a subset of health posts about postpartum return to fecundity, PPFP and integration of counseling and services along the continuum of care. At the MOH's suggestion, MCSP associated a researcher from the nearby Arsi University. The Bill & Melinda Gates Foundation provided a grant to contribute to the study, including more rigorous qualitative data collection and analysis presented in this sub-study along with study dissemination both in country and internationally. The protocol for the full study is available on clinicaltrials.gov and was approved by both Johns Hopkins School of Public Health and Oromia Regional Health bureau ethical review boards. For this sub-study, qualitative data was analyzed to explore attitudes of male involvement from the perspective of providers. Ethiopia's most populated regional state, Oromia has a modern contraceptive prevalence rate of 28.1% and the highest unmet need for FP at 29% of married women 15-49 (EDHS 2016). With respect to birth spacing, 25% of all non-first pregnancies occur within 24 months postpartum in this region (EDHS 2016). (Since we completed the study, the latest mini-DHS of 2019 shows that Oromia's contraceptive prevalence rate of 38.9% has nearly caught up with the national rate of 40.5%).

Comprised of one health center and five health posts, a primary health care unit (PHCU) is the lowest level of the Ethiopian health system. A health center provides comprehensive primary health care services, supervises and receives referrals from the five health posts. Typically, two female Health Extension Workers (HEWs) staff each health post. Ethiopia's Health Extension Program (HEP) recruits and trains HEWs to expand primary health care coverage among underserved populations within a kebele, the smallest administrative unit with roughly 1000 households (Medhanyie 2012). HEWs coordinate a network of Women Development Army (WDA) volunteers to mobilize the community to seek health services and disseminate essential health information (Damtew 2018).

A total of 38 in-depth interviews (IDIs) and six focus group discussions (FGDs) were conducted with PHCU heads, health center providers (HCPs), HEWs, and WDA volunteers (Table 1). Open-ended and semi-structured interview guides were used to explore provider perspectives of enablers and barriers to PPFP uptake and service delivery. All interviews were conducted in the regional languages of Oromo and Amharic, audio recorded, transcribed verbatim and translated into English, doubled-coded using MAXQDA software (version 2018.2), and analyzed using an inductive thematic approach (Braun 2006).

Table 1: Number of Interviews by Respondent Group

Respondent Groups	Interviews
In-depth Interviews	
Primary health care unit (PHCU) heads	4
Health center providers (HCPs)	16
Health extension workers (HEWs)	18
Focus Group Discussions	
Women's development army volunteers (WDAs)	6
Total	44

Key Findings and Conclusions

A. Socio-cultural factors influencing women's PPFP uptake –

Respondents across various levels of the health system identified gender norms and social beliefs as significant barriers to women's PPFP use in the study area. In addition to counseling women of reproductive age, providers emphasized the importance of engaging male partners, family members and religious leaders in outreach efforts because spousal opposition and religious prohibition often deter women from method use[1]. Two HEWs also mentioned that disagreements between couples about contraceptive use and desired family size sometimes results in marital tensions.

> *"In all the kebeles, husbands should be educated. This is because the wives are afraid of their husbands. There are mothers who consent during counseling but change their mind and decline [FP] due to influence from their husbands. Therefore, an intervention for husbands will greatly benefit PPFP activities to meet their objective." - HCP*

> *It is good to work with elderly and religious leaders as they are good in convincing others." - HEW*

B. Existing male engagement and community mobilization initiatives to promote PPFP uptake –

Several respondents mentioned that childbirth is often the only point of contact between expectant fathers and the health system. Men rarely accompany their wives for antenatal care (ANC) visits because they are either at work, live in a different city, or do not feel the need to attend ANC appointments based on the social perception that they have limited responsibility during the prenatal period. HCPs report that they are able to sometimes leverage childbirth as an opportunity to counsel husbands, conduct HIV tests, and discuss couples' fertility and birth spacing intentions at the health center level. One HCP also mentioned the launch of a condom distribution and group counselling program to engage men on market days. HEWs are counselling husbands on birth spacing and limiting, method choice, and women's return to fecundity after childbirth by conducting home visits, group discussions and also during social gatherings.

> *"Interviewer: How frequent is it that husbands come with their wives [to ANC]?*
> *HCP: They never come with them.*
> *Interviewer: Why don't wives come with their husbands or why do they come alone?*
> *HCP: Obviously because of lack of that attitude*
> *Interviewer: What attitude?*
> *HCP: This is because farmers do not give that much attention or value to their wives. There is an attitude that nothing can happen to her once she gets pregnant, she can give birth naturally"*
> *- HCP*

> *"We tell them [husbands] about FP on every chance we get. When they come to us individually, we help them choose from the available methods, tell them about side effects and benefits of the method, and explain the duration of the method. Then we proceed based on their decision. For example, we will tell them what is needed for a newborn after birth. Because if children are born every year, the husband is affected and also the country." - HEW*

In their capacity as frontline health workers, HEWs are instrumental in affecting community level change. HEWs are conducting PPFP discussions with male religious leaders and community gatekeepers (such as community administrative or community group leaders), using flipcharts and visual tools during

[1] Among 772 women enrolled from the same kebele and followed up under the main study, 60% were Muslim, 39% were Orthodox and 1% were "other" religions.

counseling sessions, and conducting community mobilization activities during coffee ceremonies and social gatherings. In some cases, they work with WDAs to encourage referrals for maternal, newborn and child health services and PPFP.

> *"We have also discussion with religious leaders. There are not that many [who are] interested in our district. There are religious [leaders] that object to FP. We also have contact with the district administrative unit and the [kebele] command post; we discuss with them about this. We also teach at community-based organization like Afosha [women's support group] - we teach them during community meetings. Generally, we use every opportunity we get." - HEW*

C. Barriers to male involvement in PPFP promotion

Respondents across different levels of the health system attribute low uptake of FP methods to husbands' lack of awareness about female reproductive health and needs, their dominance over women's contraceptive decision-making, fear of contraceptive side effects, and the perception of religious prohibition. Health workers and volunteers reported that the majority of men, especially older men and Muslim religious leaders, are reluctant to participate in FP discussions. Instead, WDA report being rebuked for interfering in family matters and counseling on contraceptive use.

> *"Most of the time there has been an attitude and we still see that the men are not very receptive to FP. They think that women should always bear babies and take care of them; that is what they strongly believe. Most of the time we [HEW] have conflicts with the men. They say that it is after we came that their women started to converse with/challenge them confidently." - HEW*

> *"They [husbands] consider FP as something bad. They think women become sick if they take [FP]; they say she will put us at risk which might even be lethal." - HEW*

Common barriers to effective community mobilization include resource constraints, inadequate training, work overload and rugged topography. With respect to male engagement initiatives, HEWs and WDAs reported feeling apprehensive and inadequately trained to conduct sensitive discussions with male members of the community. Since reproductive health services have largely been women-centric, they are unable to meaningfully engage men in their PPFP outreach efforts. In order to overcome this challenge, one HEW recommended training male frontline health workers as they are better positioned to initiate FP conversations with husbands and male community members.

Program/Policy Implications

- **Increase HCP's and HEW's focus on couple's counseling –** Spousal communication and husband's approval are significant predictors of modern contraceptive use. It is therefore important to encourage care seeking for couples and promote couple's counseling in addition to targeting men and women alone. Health workers can capitalize on opportunities when men accompany their wives to facility births.
- **Consider male frontline health workers** to complement and support HEWs. This suggestion came from a HEW, but other countries have worked with male mobilizers with some success (see Malawi Male Motivator project, Shattuck et al 2011)
- **Increase programmatic investment in training and sensitization programs for providers –** Providers continue to perceive FP services as women-centric and are not trained to effectively engage men in sensitive discussions. An entry point could be around explaining the Standard Days Method (SDM or CycleBeads) method of family planning to men and women. Male cooperation is

essential for effective use of that method. Furthermore, learning about SDM has been shown to increase awareness of the fertile period in a woman's cycle (Wright et al 2015). Participation in sensitization programs will reduce negative stereotypes and gender biases in service delivery.

- **Encourage husbands' involvement before and after childbirth –** The fact that childbirth may be the first and only point of contact between husbands and the health system, warrants the need to develop strategies to engage male partners along various points of the maternal and child continuum of care. Men can be involved prior to or after childbirth through counselling sessions, community-based mobilization activities, etc. Male motivators could potentially have an expanded role for other family health matters.

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