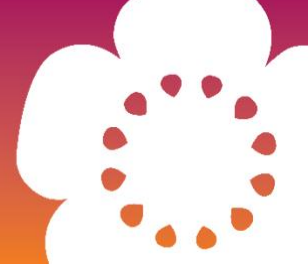


Understanding Barriers to Family Planning Service Integration in Agrarian and Pastoralist Areas of Ethiopia through a Gender, Youth, and Social Inclusion Analysis



Background

In Ethiopia, an estimated 4.5 million women of reproductive age have an unmet need for modern contraception (Sully et al. 2019). This unmet need is a result of several factors, including lack of healthcare utilization as well as negative social norms and power imbalances, which can restrict women's and girls' access to contraceptive services. A recent desk review highlighted integration of family planning (FP) services at various service delivery points as a promising approach to address the unmet need for FP in Ethiopia (Titiyos et al. 2023). Postpartum and postabortion care settings offer opportunities to address FP needs and provide integrated care. Reproductive, maternal, newborn, child, and adolescent health and nutrition (RMNCAH-N) services also serve as important opportunities to reach underserved clients in the extended postpartum and postabortion periods (Andualem et al. 2022).

Offering integrated services is one of several promising high-impact practices (HIPs) in FP. Benefits of service integration include reduced time and transit costs for clients as well as decreased burdens on the overall health system and, potentially, individual provider workloads (HIPs 2021). Moreover, FP integration is a key cost-effective intervention to address unmet need for contraception as it allows for the most efficient utilization of health services in a single visit (Ringheim, Gribble, and Foreman 2011). However, aside from a few initiatives to integrate FP into HIV and AIDS care and the health extension worker program, progress in fully integrating FP into other RMNCAH-N services at different levels of the primary healthcare system in Ethiopia, particularly in pastoral regions, remains slow (MOH 2020; MOH 2021).

The FP indicators in pastoral and agrarian regions of Ethiopia vary substantially. Healthcare access is significantly more challenging for mobile pastoralists communities than for agrarian and settled communities (Wild 2020). This lack of access is exacerbated by gender dynamics present in local pastoral communities, including social norms and power imbalances that frequently restrict women's and girls' access to contraceptive care. While gender and other sociocultural determinants undeniably contribute to poor FP outcomes, there is little evidence to demonstrate how these factors are affecting FP service integration as well as health service demand and utilization in pastoral and agrarian communities. Lack of such evidence challenges efforts to balance demand and supply side interventions when designing strategies to improve the performance of the healthcare system in these regions.

Project Summary

Ethiopia's Federal Ministry of Health is committed to introducing and scaling up integration of FP with essential RMNCAH-N services. FP integration is characterized by the joint provision of essential and nonessential RMNCAH-N and FP services by providers at the same service delivery point (such as a single public health facility), with adequate provision of FP counseling and information and a strong internal referral system (MOH 2021). Further, postpartum FP (PPFP) and postabortion FP (PAFP) are two HIPs for FP. These HIPs are based on evidence that postpartum and postabortion clients are significantly more likely to adopt modern contraception if they are offered FP counseling and services at the time of delivery or as part of postabortion care, respectively (HIPs 2017). However, there is a lack of evidence documenting implementation experience for integrating PPFP and PAFP into RMNCAH-N services; thus, the best approach to FP integration in different settings in Ethiopia remains unclear.



In 2021, EngenderHealth, with funding from the Bill & Melinda Gates Foundation, launched the Family Planning Integration in Ethiopia's Primary Healthcare System project, which aimed to inform how FP could be integrated into RMNCAH-N services as part of the broader primary healthcare system. EngenderHealth collaborated with the Federal Ministry of Health and partnered with Addis Ababa University School of Public Health, Jigjiga University, and Wolaita Sodo University to implement this project. Through this project, we supported the government by undertaking a formative research assessment that explored issues associated with gender inequality, social inclusion, and female empowerment and identified barriers to the integration of FP in RMNCAH-N services.

Study Purpose and Research Question

Recognizing that gender, youth, and social inclusion (GYSI) are critical considerations affecting women's and adolescents' access to health information and services, EngenderHealth commissioned a study to understand how gender and youth determinants affect health service utilization in pastoralist zones in the Somali region and in an agrarian zone in the South Nations, Nationalities, and People's (SNNP) region.

The study also explored promising interventions for addressing gender inequality, social inclusion, and female empowerment challenges that hinder integration of FP into RMNCAH-N services. This brief presents findings from the formative assessment related to the feasibility of FP integration into the current primary healthcare system, including into community health services in pastoralist and agrarian settings.

Research question: What factors affect access to PFP and PAFP service integration into RMNCH-N services in pastoralist and agrarian settings of Ethiopia?

Methodology

EngenderHealth, in partnership with Addis Ababa University, Jigjiga University, and Wolaita Sodo University, conducted a formative assessment from June to July 2022 to explore the local context and identify barriers to the integration of PFP and PAFP into RMNCAH-N services.

Sample

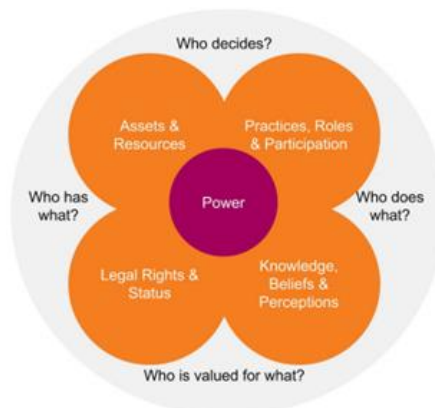
Researchers identified study participants from the catchment area of 15 health facilities in the Somali region and 15 health facilities in the SNNP region. In the Somali region, the study team conducted 53 in-depth and key informant interviews and facilitated eight focus group discussions with participants from urban and rural settings covering two pastoral zones (Fanan and Jarar). The study team facilitated in-depth interviews and focus group discussions with postpartum clients, their partners, and adolescent girls and boys and conducted key informant interviews with service providers and health officers. In the SNNP region, the study team conducted 41 in-depth and key informant interviews and facilitated six focus group discussions with similar groups.

Framework

Researchers employed EngenderHealth's GYSI Analysis Framework and Toolkit to assess sociocultural factors and other barriers and/or facilitators that affect girls' and women's abilities to access and adopt modern contraceptive methods during the postpartum and postabortion periods (EngenderHealth 2021). We assessed the four dimensions of power defined in the GYSI framework (see Figure 1) at individual, community, and institution, system, and policy levels that may help or hinder the integration of PFP and PAFP with RMNCAH-N services. This includes specifically:

- > Resources and assets available to women and girls, particularly those related to access to FP and other health services, access to income generating activities, and access to and control over financial resources and services
- > Practices, roles, and participation of women and girls related to gender equality and rights, including their decision-making powers
- > Knowledge, beliefs, and perceptions related to gender norms, social norms, and health information and access
- > Legal rights of women and girls in relation to sexual and reproductive health and rights and integrated FP access

Figure 1: GYSI Framework



Data Analysis

Professional transcribers familiar with the local context and dialect transcribed audio recordings from the interviews and focus group discussions in Somali (Somali region) and Amharic (SNNP region) and then translated them into English. The study team employed NVivo and Open Code software to code the transcripts using a content analysis method based on the four dimensions of power. The team analyzed data under each dimension and across each level to identify gaps and disparities at individual, community, and institution, system, and policy levels. We obtained ethical clearance from the Institutional Review Board of the College of Health Sciences at Addis Ababa University to undertake this study. The study team informed all respondents of the purpose of the study, ensured confidentiality, and obtained consent.

Findings

The patriarchal culture that dominates both pastoralist and agrarian communities in Ethiopia manifests in gender inequities that affect the division of labor and access to and control over resources, power over healthcare decisions, knowledge and beliefs related to FP, access to FP services, and laws and rights as well as customary traditions.

Unequal Divisions of Labor and Inequitable Control over Resources

In pastoral communities, girls and women bear the responsibility of household chores and childcare, while boys and men may spend time participating in income generating activities and socializing outside the home. Women’s and girls’ household responsibilities often prevent them from being able to seek healthcare. Further, men are typically responsible for making decisions about livestock and associated incomes. For instance, women and girls lack control over decisions related to buying and selling animals, buying animal feed, and migrating livestock to different locations. This lack of control over their livelihoods inhibits their ability to secure sustainable incomes and to participate in decisions about how family incomes are used, including for accessing maternal healthcare and FP services.

In the agrarian community, there are similar gender differences in terms of access to and control over livelihood resources, which are reflected in an unfair distribution of resources that benefits men. Women in the agrarian communities further noted that access to

“I don’t have any separate income from my household and my husband has the decision-maker power over the resources.”

Adult Female, Pastoral Community

“Many people perceive that using contraceptive drugs or methods needs a special meal. Those who want to use FP, there should be something like milk and sorghum in the house so that she will be able to take care of herself.”

Adult Female, Agrarian Community

food is a challenge because food is scarce and, per customary traditions, ensuring men and boys have enough healthy food is the priority. As a result, women and girls are often without enough food or without high-quality food. In addition to affecting women's and girls' nutritional status, this affects FP outcomes, as quality food is thought to be a critical precondition for FP use. Specifically, many believe that a nutritious, balanced diet is essential to avoiding health risks and side effects while using contraception.

Unequal Health Decision-Making Powers

Gender dynamics and power imbalances hinder women's and girls' access to FP services in multiple ways. For instance, in addition to affecting women's and girls' access to household resources, men may also restrict women's movements. Further, while couples in both pastoral and agrarian communities often discuss FP matters together, men usually have the ultimate decision-making power.

Adolescent girls and women from pastoralist communities described the power that men have as a critical barrier to their ability to access essential healthcare, including FP services. Women must obtain approval from their husbands before accessing health services and women are not allowed to travel long distances—for instance, to a health facility—without the approval of their husbands. Even if accessing FP is possible, secretly using FP can create result in negative repercussions, including divorce and legal prosecution.

While agrarian communities also noted that couples may discuss FP use together, male opposition is similarly a barrier to FP use. Married women's ability to access to FP is limited particularly by their husbands' resistance to FP for religious, social, and political reasons.

Knowledge and Perceptions of FP

There is little knowledge of available FP integrated services in both pastoral and agrarian communities. However, knowledge varies across locations and demographic profiles of individuals. For example, educated women and those from urban areas are more likely to delay marriage, adopt a FP method, breastfeed newborns, and practice birth spacing. The mobile lifestyle of pastoralists results in challenges establishing connections with static health services, which thereby inhibits their access to FP information and services. In agrarian communities, lack of knowledge is attributed to living in remote areas without access to mass media and to low literacy rates that prevent individuals from being able to read materials containing information about FP overall and about where FP integrated services are available.

Negative perceptions of FP affecting health-seeking behaviors and service utilization across both pastoral and agrarian communities are linked to cultural and religious beliefs and practices. For instance, early marriage is commonplace, solidifying relationships among clan members, and is linked to social pressures to conceive, which prevents FP uptake. In addition, myths about FP and infertility persist, as do misconceptions related to FP methods, such as the idea that implants can cause abortions or that intrauterine devices can migrate from the uterus

"Since most of the decisions belong to the man, the women may ask him that she can take the family planning services then he may reply by saying, 'Do you want to make me *Gablan* [someone without children]?' This is why family planning coverage is low in Somali society because most of the decisions belong to men so if the women ask their husband to use the services they don't allow and if the women use secretly, it will bring conflict."

Adolescent Male, Pastoral Community

"If the woman is not allowed to use these services without her husband permission, she will prefer to abstain rather than getting divorced so she will deliver yearly."

Adolescent Male, Agrarian Community

"Somali people are against the taking FP except only few people who studied."

Adolescent Male, Pastoral Community

"Even though the women who take the family planning are invisible in the community, if the community see women take the family planning [they] are discriminated and marginalized."

Adolescent Male, Pastoral Community

to other parts of the body. In pastoral communities, traditional beliefs and practices, including men's and community leaders' desires for large families to support large clans, hinder acceptance of FP. Additionally, beliefs that contraceptive use is inadvisable until after a first pregnancy and myths that a new mother will become sick if she ventures outside, for instance, to access PPF, prevent uptake.

Agrarian respondents cited cultural barriers to FP, including gender discrimination and stigma, especially in small communities where use of FP may become known by others. Women from agrarian communities further mentioned beliefs that adopting modern contraception in the immediate postpartum and postabortion periods leads to exhaustion and pain and explained that women prefer to rest and consider a natural FP method. One participant also noted that new mothers stay with their parents after giving birth and prefer to wait until they return to a facility for the child's vaccinations to consider FP.

Respondents also highlighted religious barriers, demonstrating the important role religious institutions play in influencing FP acceptance and uptake. Respondents cited religion as a key reason for not accepting FP and reported that some religious leaders do not allow women to use FP. In the pastoral areas, respondents said that some religious leaders have begun to publicly promote FP; however, many felt that the role of religious institutions in FP is still underestimated and that religious scholars have the potential to influence communities and to destigmatize FP as it relates to religion.

Limited Access to FP Services

Across both pastoral and agrarian communities, those living in rural areas have limited access to healthcare facilities and often lack community or home-based services. Respondents cited the lack of quality healthcare facilities within their villages and the lack of transportation (including ambulances) to health facilities in nearby areas as critical barriers to FP. Where facilities exist and are accessible, respondents explained that long wait times and unavailability of medications and proper infrastructure prevent them from accessing care. Healthcare professionals emphasized the need for access to a full range of contraceptive methods at facilities to fulfill client's needs. Poor supply chain management, particularly shortages of long-acting reversible contraceptives at lower-level health facilities, prevents providers from offering comprehensive FP options. Further, health facilities have not adopted an integrated FP approach to manage and address the different needs of different clients.

Formal healthcare systems in pastoralist settings are generally quite weak. Seasonal mobility and limited accessibility to health facilities and providers, unfriendly attitudes of health providers when and where they are accessible, and preferences for female health professionals all prevent pastoralist girls and women from accessing FP services. These barriers are exacerbated further by climate disasters (such as frequent droughts) and political

"When we recommend FP [after birth], they say 'Oh I'm in pain; I have abdominal cramp or lower back pain due to delivery.' They think taking long-acting family planning, especially a loop [intrauterine device] create more pain and discomfort so they have fear of taking it before 45 [after] delivery."

Healthcare Provider, Agrarian Community

"Some people say it is against the will of God to use it [FP]. Especially the wives of religious leaders don't want to use it."

Adult Female, Agrarian Community

"[The community] is 30 km far from the health center and clients coming from there suffer to get transportation. They may use motorcycles and they pay 120 birrs for a single trip."

Adult Female, Pastoral Community

"If it is necessary to do an IUCD [intrauterine device], there is no separate bed to perform this procedure. So, in terms of infrastructure, there is a problem... Most family planning is intended for secret room, but the center space is small, and rooms are narrow."

Healthcare Provider, Pastoral Community

insecurity that restrict mobility further. Healthcare professionals identified inadequate infrastructure (including the lack of private spaces for FP counseling and services) and insufficient equipment (such as beds to perform FP procedures) as additional barriers to service delivery. However, respondents cited the availability of no-cost services as a facilitator for increased access to PFP and PAFP services.

Agrarian communities also experience challenges associated with geographic access to health posts; however, the lack of trained midwives and the need for clients to pay for service-related commodities (such as gloves) despite the service itself being free, are additional barriers to FP services for these communities. For instance, several agrarian respondents highlighted the shortage of midwives to deliver PFP and PAFP services, a gap that is often covered by nurses and other public health professionals.

Participants from both pastoral and agrarian communities highlighted the value of health extension workers and other community structures, such as the Women's Development Army and monthly pregnant women's conferences coordinated by health extension workers. These initiatives are critical to facilitating positive change at individual and community levels—including by supporting women and girls in accessing health services as well as in supporting female health workers in attaining healthcare positions—and should continue to be prioritized to support FP uptake. Increasing the number of female healthcare providers would improve gender responsiveness of services, particularly in the Somali region, where most health providers are male, which has hindered acceptance of health education and services among girls and women. Moreover, there is a similar lack of women's leadership in policy and decision-making spaces, such as those where healthcare budgets are allocated. This has begun to change in recent years, but must be supported further to address gender and power imbalances within the health sector and within the communities served.

"We have a shortage of trained professionals ...most of the time trained health workers shift to another facility like hospitals and health centers near to the urban [centers]."

Healthcare Provider, Agrarian Community

"Women leadership have great effect on these services. When there were male providers at MCH [maternal and child health], few women used to visit. Currently most of the MCH heads are female so many more women visit the health center without feeling any shyness they come and get the service."

Health Manager, Agrarian Community

Legal Rights and Customary Traditions

Women across both communities struggle with a lack of adequate legal rights, particularly as customary traditions remain more powerful than the government's laws and justice systems. Customary laws and norms are deeply embedded in societal structures and continue to guide the lives of individuals in these communities, preventing girls and women from fulfilling their economic and social rights. Further, gender is not fully integrated into the healthcare system and health facilities have not adopted integrated FP approaches to address the different needs of the different genders.

Respondents from the pastoral communities cited lack of awareness of existing laws and associated rights, especially with regard to PFP and PAFP; however, they also highlighted their trust in community leaders, such as religious scholars, to disseminate FP and other health information. Health professionals and government officials from the agrarian communities reported that while some community members have become aware of FP policies through the media, health facilities, and schools, further communication of this information is needed to ensure understanding and acceptance.

Recommendations

Our study highlighted challenges associated with gender norms, cultural traditions, religious beliefs, and community misconceptions that promote male dominance and restrict women's and girls' abilities to make FP decisions and access healthcare. Understanding the depth of culturally entrenched and structural gender-related barriers, any future programming must be designed and implemented in partnership with local leaders and decision-makers (including male heads of households). Further, we recommend prioritizing women-led advocacy and decision-making initiatives to help address this power imbalance. Interventions should seek to increase women's agency and decision-making powers at all levels, including at the household level, but with a careful balance of male engagement to ensure community support.

Our findings demonstrate limited knowledge of available integrated FP services. As the community plays a significant role in influencing the use of FP, we recommend strengthening the capacity of health professionals to engage with community members to identify shared values and to counter myths and misconceptions and to promote FP acceptance, particularly during the postpartum and postabortion periods. Other community change agents, such as religious and clan leaders, must also assist with improving awareness and acceptance of FP services, as this is critical in shifting negative views of FP. Messaging and interventions should be tailored to the local context; for example, in SNNP, interventions should consider the intersection of nutrition and FP, and identify opportunities to address both issues through integrated approaches. Interventions should also incorporate messaging to address cultural practices related to FP, including harmful traditional practices such as early marriage.

At the policy and systems level, facilitating the availability of and accessibility to comprehensive FP information and a comprehensive range of methods at community, household, and individual levels is crucial to supporting voluntary FP uptake. Interventions to strengthen healthcare worker recruitment, capacity, motivation, and retention (particularly for midwives) as well as to address infrastructure barriers within facilities (such as lack of private rooms) are also needed. Encouraging women's leadership and decision-making authority within the health system must be a component of this work.

Summary

Patriarchal ideals deeply embedded in societal structures prevent girls and women from fulfilling their economic, health, and social rights in both pastoralist and agrarian communities in Ethiopia. It is critical to understand underlying social factors affecting FP uptake when designing interventions to meet the unique needs of these populations in Ethiopia. Opportunities exist to promote integrated FP services. These include improving women's and girls' decision-making powers, supporting healthcare providers to offer accurate and comprehensive FP information, working with influential religious and community leaders to transform beliefs and perceptions related to FP, improving access to a full range of FP methods, and facilitating awareness of and adherence to established women's and girls' rights.

Acknowledgements and Suggested Citation

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