



# ADDRESSING GENDER ISSUES IN POSTPARTUM FAMILY PLANNING SERVICES

## Background

The postpartum period is an important window when many women and their partners may desire access to reliable and high quality family planning services. Globally, 50-60% of women make prenatal visits or have contact with health care providers at or following delivery, offering a high likelihood of contact with the health care system. According to health survey data from 27 countries, 65% of women who are 0–12 months postpartum want to avoid a pregnancy in the next 12 months but are not using modern contraception (Ross & Winfrey, 2001). Postpartum family planning (PPFP), defined as counseling and services to prevent unintended and closely spaced pregnancies through the first 12 months following childbirth, is imperative to reduce preventable mother and newborn morbidity and mortality and improve health outcomes for families.

Spacing pregnancies by at least 24 months after a live birth (or at least six months after a miscarriage or induced abortion) could avert an estimated 25%-40% of maternal deaths and 44% of newborn deaths, as well as reduce other neonatal morbidities (Singh et al., 2009; USAID, 2007). While pregnancy spacing has numerous health benefits for the mother and baby, it is necessary to take local social and cultural contexts into account when providing care since women and couples may have personal, medical, or socio-cultural needs and pressures that can influence the decision to space pregnancies and adhere to family planning methods. Information and access

### Box 1. Gender issues in PPFP services

- Gender-related values and traditions
- The role of male partners, mothers-in-law, and other actors in PPFP decision-making
- Addressing the needs of girls in PPFP
- Access to and utilization of quality health care
- Gender-based violence

to contraceptive services, household and community beliefs and gender roles, expectations, and decision-making power all influence decisions and behaviors around PPFP.

## Gender Issues in PPFP Services

### *Gender-related values and traditions*

Gender-related values and traditions affect the ability of women and their partners to access and utilize quality family planning services. For example, in many countries, the ability to have children shapes one's social status, and many men and/or women desire large families, yet not all couples agree on family size. Husbands, mothers-in-law, and co-wives can play a prominent role in deciding family size and influencing reproductive decisions and care. Sons are considered highly desirable in many cultures, since a male child is often expected to earn money to support the family later in life. A woman may be less likely to accept PPFP

after the birth of a female child due to the culturally-driven expectation to give birth to a male child (Mittal & Kashyap, 2011).

Religion also influences PPFP decisions by fostering traditions and beliefs around contraception and birth, yet the interpretations of these traditions and beliefs may vary depending on the geographic and social landscape. For example, the Qur'an sanctions breastfeeding for at least two years for better nutrition and offers many passages that value the girl child. Other local traditions and norms may influence decision-making around uptake of PPFP and can all influence access and utilization of PPFP.

Gender-sensitive PPFP improves the utilization of services by working to understand local values and traditions in order to implement PPFP programs that are culturally relevant and effective. Working to promote education and greater understanding around values and traditions that are potentially harmful to the health and wellbeing of mothers, children, and families is also important for PPFP success.

### *The role of male partners, mothers-in-law, and other actors in PPFP decision-making*

A male partner often plays an important role in the decision for a woman to use family planning methods in the postpartum period. Accessing short-acting contraceptives that require regular contact with a provider can be very challenging without the support of a male partner and other family members, especially

## AUGUST 2014

This brief report on integrating gender considerations in PPFP services was written by Caitlyn Lutfy, Taroub Faramand, Megan Ivankovich, Elizabeth Romanoff Silva, and Kathryn Krueger of WI-HER LLC (Women Influencing Health, Education, and Rule of Law) for the USAID Applying Science to Strengthen and Improve Systems (ASSIST) Project, which is funded by the American people through the United States Agency for International Development (USAID) Bureau for Global Health, Office of Health Systems. The USAID ASSIST Project is managed by University Research Co., LLC (URC) under the terms of Cooperative Agreement Number AID-OAA-A-12-00101. URC's global partners for USAID ASSIST include: EnCompass LLC; FHI 360; Harvard University School of Public Health; HEALTHQUAL International; Institute for Healthcare Improvement; Initiatives Inc.; Johns Hopkins University Center for Communication Programs; and WI-HER LLC. For more information on the work of the USAID ASSIST Project, please visit [www.usaidassist.org](http://www.usaidassist.org) or write [assist-info@urc-chs.com](mailto:assist-info@urc-chs.com). For more information on integrating gender considerations in PPFP, please contact [tfaramand@wi-her.org](mailto:tfaramand@wi-her.org).

for impoverished women and women in rural areas (Creanga et al., 2010). Even if a woman has personal assets, she may not use her resources to access contraception if her husband or male partner does not give his permission, either due to her own decision to wait for her husband's input or due to the decisions of health care providers. Therefore, a male partner's cooperation related to access, payment, and support for the initial uptake of PFPF services and extended use of modern family planning methods may be necessary. PFPF services that are not responsive to male influences may go unutilized and can result in improper use of contraceptives and other resources (see Box 2).

Due to their status within families, mothers-in-law can also be important decision-makers regarding reproductive health and family planning choices (Kouyate et al., 2010). In some settings, co-wives or community elders also play an important role in such decision-making. PFPF programs should be responsive to actors such as mothers-in-laws and co-wives.

Engaging male partners in decisions and processes to space or prevent pregnancies is important to reduce maternal mortality and contributes to male partners taking control of their own fertility and considering male-specific family planning methods such as condom use or sterilization. Mothers-in-law in particular have the potential to be influential advocates and important supporters for access and utilization of PFPF for the women in their families. Health providers should work to provide a welcoming and safe environment as well as resources and support to women in order to empower them to manage these influences as well as their personal health needs.

While engaging male partners and mothers-in-law in women's health care can have positive benefits, the power dynamics and relationship of each couple and family is unique. For some women, engaging a male partner or mother-in-law may be detrimental to her health and safety. It must ultimately be the woman's choice whether or not to engage her male partner, and health care providers must be prepared with the resources and information necessary to care for the client's needs based on her decision (see Box 3).

### Addressing the needs of girls in PFPF

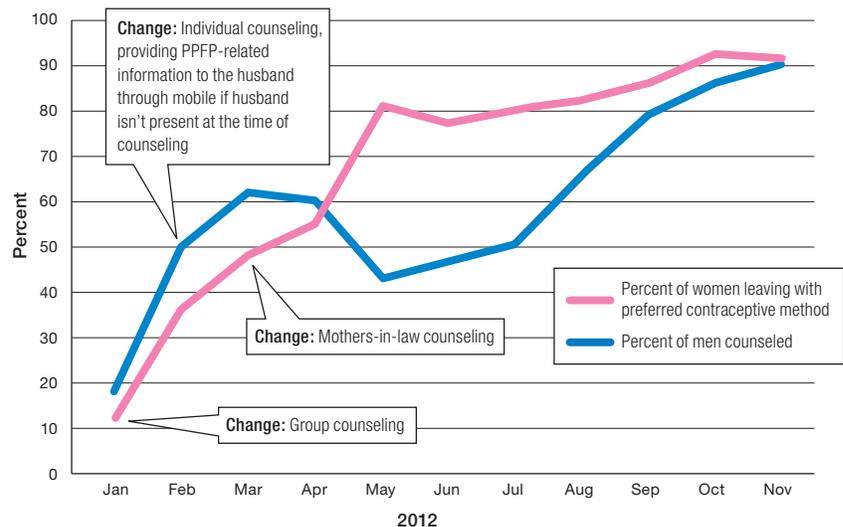
Every year, an estimated 16 million girls give birth before they reach age 18. Adolescent pregnancy can have detrimental health effects

## Box 2. Improving family planning services in Afghanistan by addressing gender issues

The USAID Health Care Improvement (HCI) Project incorporated husbands and mothers-in-law into a PFPF intervention in five maternity hospitals in Kabul, Afghanistan. The HCI team recognized two key barriers influencing quality and access to PFPF services in Afghanistan: a lack of private counseling spaces within the postpartum ward and the inability of women to make independent decisions regarding contraceptive use without a husband and/or mother-in-law.

To address this, husbands and their wives were invited to participate in private PFPF counseling sessions prior to hospital discharge. Men who were unavailable to attend PFPF counseling sessions at the hospital were contacted on their mobile phones. Counseling sessions targeting mothers-in-law were also initiated prior to client discharge. Based on these changes, the proportion of women who received their preferred family planning method and the proportion of men participating in PFPF counseling both increased substantially.

**Proportion of postpartum women who received family planning counseling with husbands and left with their preferred methods in 5 hospitals, Kabul, Afghanistan, January – November 2012**



for both mother and baby. Girls aged 10-14 are five times more likely to die during pregnancy or childbirth than women aged 20-24, and worldwide, health complications related to pregnancy and childbirth is the leading cause of death among girls 15-19. The risk of newborn death is 50% higher for newborns born to adolescent mothers (WHO, 2012a). In addition to their physical vulnerabilities, married girls can face significantly decreased decision-making power and often are less able to negotiate the use of PFPF methods and access health care and family planning services (PRB, 2007). While increasing the reach of health care services to girls before they become pregnant is ideal, the postpartum period offers a unique opportunity to provide services to adolescent mothers, a vulnerable and often hard-to-reach population.

### Access to and utilization of quality health care

Worldwide, 50% of all births occur outside health care facilities (MCHIP, 2013), and 70% of women who do not deliver in facilities receive no postpartum care (WHO, 2012b). In addition to physical barriers, gender issues also influence access to care. In some societies, women are not allowed to leave the house during the postpartum period, which is a missed opportunity to promote healthy behaviors affecting women, newborns, and children (Warren et al., 2006).

Health care providers may also project their own socially-driven, negative attitudes and beliefs on clients, causing biased care that perpetuates stigma and may prevent clients from accessing PFPF services. Many women

### Box 3. Improving PPF services in Niger

In Niger, the USAID Applying Science to Strengthen and Improve Systems (ASSIST) Project is working in 16 health facilities to provide quality, client-centered care through the provision of a method mix of family planning services. Early on, improvement teams identified that women delay making important family planning choices or refuse care to wait for input and permission from their husbands. This highlights the need to involve male partners in PPF—at a woman’s discretion—and for effective advocacy and counseling to educate women, partners, and families on the need to adopt PPF methods.

The ASSIST team in Niger sensitized all

health facility teams on gender issues affecting PPF. Improved documentation practices contributed to an improvement in the proportion of women with or without a male partner receiving PPF counseling from 0% to 80%. Health teams are raising awareness about the importance of male involvement, addressing stigma, and responding to religious and cultural barriers associated with male partner involvement in family planning. The team is looking into barriers such as inheritance, which is associated with having male sons and a large number of children, to change attitudes of families and communities around the importance of family planning and PPF.

with HIV report that they have felt stigmatized by health care providers when seeking health services while pregnant or when considering becoming pregnant. Providing training to health care providers regarding the harm caused by stigma and discrimination is necessary to ensure that health care facilities are safe and welcoming spaces where clients are assured of unbiased, quality family planning services.

Providers and community health workers must be sensitive to the family planning needs and perspectives of men and women and be open to working with both sexes. All women should have the same quality of care and access to PPF options and stigma surrounding the woman’s age, HIV-status, marital status, ethnic or socioeconomic status, or other specific situations, such as rape or abortion should not be present.

#### Gender-based violence

Fear of gender-based violence (GBV) is an issue that has a significant impact on a woman’s ability to access and utilize PPF methods and services. Intimate partner violence can have serious consequences on a woman’s prenatal and postnatal health, as well as her ability to make autonomous health care choices, access health services, and utilize the family planning methods of her choice (PRB, 2010). Women in abusive relationships face a higher risk of unintended pregnancy and need additional protection and family planning options. Health care providers can sometimes be unaware or unresponsive to threats of GBV that could be a consequence of or detrimental to PPF.

To prevent unintended pregnancies among women who have experienced GBV or fear their male partner’s reaction to their uptake of PPF, health care providers should be aware of the signs of abuse, be sensitized to the needs of victims, and provide available resources. It’s important that clinics offer women covert contraceptive methods with which the intimate partner cannot interfere, such as an injectable or other long-acting method that would be easier to conceal for longer periods (Miller et al., 2010). Men—especially if not educated on the overall health and benefits of pregnancy spacing and family planning—may become angry or frustrated if they discover that their partner is using contraception or refuses or is unable to conceive. This reinforces the importance of PPF programs understanding men’s attitudes, knowledge, power, and behaviors, and incorporating these needs into PPF service delivery.

#### Considerations for Integrating Gender into PPF Services

##### 1. Identify and address specific gender issues that may influence women’s and couples’ PPF decision-making

- Conduct a gender analysis to examine the gender relations and issues prevalent in the community which may impact reproductive health behaviors
- Determine which types of methods will be acceptable and feasible from culturally-sensitive, cost, and logistics standpoints
- Address attitudes and values favoring boy children directly with women and men

- Identify and employ gender-sensitive strategies that promote the ability for women to make educated and autonomous family planning choices, where appropriate
- Explain the health benefits of PPF for mother and baby as well as other benefits to both women and male partners

##### 2. Utilize opportunities along the continuum of care to promote access to high-quality PPF

- Determine the best opportunities to reach both men and women (e.g., immediately following birth, at a woman’s postnatal check-up, at child immunization appointments)
- Leverage any contact a woman has with the informal and formal health system during the immediate and extended postpartum period to promote “one-stop” services that include family planning counseling and method delivery (e.g., facility- and home-based postpartum visits, child health promotion contacts, sick child contacts)
- Engage community health workers in PPF to reach women who face barriers to accessing care

##### 3. Engage male partners and other influential actors, such as mothers-in-law, when appropriate

- Promote male and family involvement where appropriate and identify opportunities to engage male partners throughout the continuum of care, while respecting a woman’s choice as to whether her partner and family are involved
- Provide targeted education sessions to mothers-in law, elders, men’s groups, community groups, and religious and influential leaders about the health benefits of pregnancy spacing and family planning and how different methods work
- Integrate health services into clinic visits so clinics appeal to men for their personal health needs
- Create a private and safe environment for family counseling and service delivery where both women and men can feel comfortable and at ease; in cultures where men do not attend births, create separate spaces for PPF counseling, involve men in family planning sessions tailored to fathers, or engage male partners and family members in counseling via mobile devices

#### 4. Train and provide continuous support to health care providers and community health workers to address gender issues affecting PFP

- Educate the workforce on a wide range of methods for contraception, how they can be accessed, and the risks and efficacy of each method
- Train health workers to counter stigma and welcome male partners, when agreed upon by the female client, in clinical visits and PFP discussions; also train health care workers against projecting their own beliefs on clients
- Sensitize providers to patient issues that may generate socially-driven, negative attitudes, such as HIV-positive mothers, unmarried or single women, and those seeking post-abortion treatment, care, and support
- Ensure health care workers are aware of different religious and cultural beliefs within their service area and educate couples on other available methods

### Resources to learn more

#### K4Health. Postpartum Family Planning Toolkit.

Available at: <http://www.k4health.org/toolkits/ppfp/essential-knowledge>

This toolkit provides a multitude of valuable resources for capacity building at facility and community levels in PFP.

#### World Health Organization. Programming Strategies for Postpartum Family Planning.

Available at: [http://apps.who.int/iris/bitstream/10665/93680/1/9789241506496\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/93680/1/9789241506496_eng.pdf)

This publication was created for program planners and managers use as a resource when designing interventions to integrate PFP into national and subnational strategies, including valuable information and country specific case studies on PFP.

#### USAID. Strengthening family planning policies and programs in developing countries: An advocacy toolkit.

Available at: <http://www.policyproject.com/pubs/manuals/Family%20Planning%20Toolkit%20final.pdf>

This advocacy toolkit was designed to assist family planning/reproductive health advocates to promote policy dialogue on the health, social, and economic benefits of increasing access to family planning services using culturally-relevant arguments to promote family planning and birth spacing in their particular settings.

#### 5. Encourage FP options and choices that reduce risk of GBV and unintended pregnancies resulting from GBV or coercion

- Sensitize health providers to signs of GBV and the unique health care needs of victims
- Give women the choice of whether a male partner, mother-in-law, or anyone else is involved and aware of her decision, and provide quality resources and care according to her decision
- Provide access to long- and short-term contraception methods in a safe environment, when possible, responding to individual needs of the client
- Provide education on side effects and proper use
- Ensure that those who require surgical removal or follow-up care are able to access such services

#### 6. Collect and analyze gender-sensitive data to inform program design and monitoring

- Track and continuously monitor data on the age of mothers receiving PFP services in order to know who is accessing services, track outcomes for women and girls in different age groups, and provide vulnerable groups of females, such as adolescent girls and older women, age-specific services that respond to their needs
- Design gender-sensitive indicators to track male participation and participation of other family members in PFP services to determine how engaging family members impacts PFP uptake
- Include indicators to track adverse events, such as GBV, in order to ensure that patients are not experiencing unintended consequences

### References

Creanga A, Gillespie D, Karklins S, Tsui A. 2010. "Low use of contraception among poor women in Africa: an equity issue." Available at: <http://www.who.int/bulletin/volumes/89/4/10-083329/en/>

Kouyate A, Nash-Mercado A. 2010. *A Guide for Developing Family Planning Messages for Women in the First Year Postpartum*. ACCESS-FP: Baltimore, Maryland.

MCHIP. 2013. "A Path to Planned Pregnancies: Opportunities to Talk About Birth Spacing and Family Planning Along the Reproductive Health Journey." Available at: [http://www.usaid.gov/sites/default/files/documents/1864/PPFPInfographic\\_sm.pdf](http://www.usaid.gov/sites/default/files/documents/1864/PPFPInfographic_sm.pdf)

Miller E, Jordan B, Levenson R, & Silverman JG. 2010. "Reproductive Coercion: Connecting The Dots Between Partner Violence and Unintended Pregnancy." Available at: <http://www.arhp.org/publications-and-resources/contraception-journal/june-2010>

Mittal A, Kashyap I. 2011. "A nurse-midwife champions postpartum family planning in rural Bihar." *JHPIEGO*, Retrieved from <http://www.jhpiego.org/sw/content/nurse-midwife-champions-postpartum-family-planning-rural-bihar>

Population Reference Bureau (PRB). 2007. "Addressing cross-generational sex: A desk review of research and programs." *USAID BRIDGE project*, Available at: [http://www.prb.org/igwg\\_media/AddressingCGSex.pdf](http://www.prb.org/igwg_media/AddressingCGSex.pdf)

PRB. 2010. "Gender-based violence: Impediment to reproductive health." *USAID Office of Food For Peace Occasional*

*Paper 7*, Available at: [http://www.prb.org/igwg\\_media/gbv-impediment-to-RH.pdf](http://www.prb.org/igwg_media/gbv-impediment-to-RH.pdf)

Ross J, Winfrey W. 2001. Contraceptive use, intention to use and unmet need during the extended postpartum period. *International Family Planning Perspectives*. 27(1): 20–27. Available at: [http://www.prb.org/igwg\\_media/AddressingCGSex.pdf](http://www.prb.org/igwg_media/AddressingCGSex.pdf)

Singh S et al. 2009. "Adding It Up: The Costs and Benefits of Investing in Family Planning and Maternal and Newborn Health." New York: Guttmacher Institute and United Nations Population Fund. Available at: [http://www.unfpa.org/webdav/site/global/shared/documents/publications/2009/adding\\_it\\_up\\_report.pdf](http://www.unfpa.org/webdav/site/global/shared/documents/publications/2009/adding_it_up_report.pdf)

USAID. 2007. "Postpartum Family Planning Technical Consultation-Meeting Report." Available at: <http://access-tohealth.org/toolres/pubs.htm#ppfp>

Warren C, et al. 2006. "Opportunities for Africa's Newborns. Cape Town, South Africa: Partnership for Maternal, Newborn and Child Health." World Health Organization, 79–90. Available at: <http://www.who.int/pmnch/media/publications/africanewborns/en/index.html>

World Health Organization (WHO). 2012a. "Statement for Collective Action for Postpartum Family Planning." Available at: [http://www.who.int/reproductivehealth/topics/family\\_planning/Statement\\_Collective\\_Action.pdf](http://www.who.int/reproductivehealth/topics/family_planning/Statement_Collective_Action.pdf)

WHO. 2012b. "Adolescent pregnancy factsheet." Available at: <http://who.int/mediacentre/factsheets/fs364/en/>

### USAID Applying Science to Strengthen and Improve Systems

University Research Co., LLC, 7200 Wisconsin Ave., Bethesda, MD 20814-4811 USA

TEL 301-654-8338 • FAX 301-941-8427 • [www.usaidassist.org](http://www.usaidassist.org) • [assist-info@urc-chs.com](mailto:assist-info@urc-chs.com)