Improving access to and utilization of postpartum family planning: Why gender matters

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Last month, I had the privilege to travel to a rural health center in Tanzania to observe the great work of the USAID ASSIST Project. While waiting for members of the clinic’s quality improvement team to attend to patients before starting the gender integration training, we had time to explore the clinic and talk with patients.

In the ASSIST-supported maternity ward, female patients occupied three of the four beds and all had delivered in the previous 12 hours. The first woman we spoke with was all smiles, and her baby was strong, loud, and already a pro at breastfeeding. With the nurse interpreting, we asked the patient about her delivery, how she was feeling, and even what contraceptive method she was planning to use moving forward.

The other two patients were not so lucky. They were both approximately sixteen years old. They appeared exhausted, in pain, and after a brief examination, it was clear they were dehydrated and anemic. One even suffered severe tears as a result of female genital mutilation/cutting, a common practice in her community, which can complicate delivery.

As a public health professional and a lifelong advocate of family planning, I had a million questions: Where are the fathers? Where are the health providers when so many people need care? Were these pregnancies planned? Do these girls want to get pregnant again? What voice do they have in making these decisions? What family planning methods do they know and which are accessible and affordable in their communities? But with an understaffed clinic and serious health considerations at hand, I didn’t hear these questions discussed.

The postpartum period is an important time when many women and their partners may desire family planning services. Postpartum family planning (PPFP), defined as counseling and services to prevent unintended and closely spaced pregnancies through the first 12 months following childbirth, is critical 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.
Yet we all know doing what is best for our health isn’t always easy, and social and cultural contexts often influence care. There are many gender issues that influence the use or non-use of PPFP services [3] such as gender-related values and traditions; the role of partners, mothers-in-law, and other actors in PPFP decision-making; the unique needs of girls; access to and utilization of quality health care; and risk of gender-based violence. The unique social and cultural contexts of each community must be considered when providing services to improve quality of care and improve health outcomes.

Having worked in Mozambique as a Peace Corps Volunteer, I understand the challenges in providing high-quality health care, the limitations of working in a low-resource setting, and the influence of cultural practices and traditions on health decision-making. But I also know the creativity and innovation of people working on the ground. ASSIST staff and the QI teams they work with are working hard every day to test community-based changes to improve access to and quality of care for all. As a partner on the USAID ASSIST Project, we at WI-HER LLC are working to support the teams to ensure that staff understand the importance of considering gender and teaching them how to integrate gender into relevant projects.

**Topic(s):** Family Planning and Reproductive Health [4]
Post-partum family planning [5]
Gender [6]
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