



## Together We Decide:

# Using behavioral science to improve postpartum contraceptive uptake

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## BACKGROUND

The eastern region of Uganda has some of the highest fertility rates in the country, ranging from 5.1 to 7.9 children per woman.<sup>1</sup> Currently, 28% of married women in Uganda have an unmet need for family planning (FP).<sup>2</sup> This figure increases during the postpartum period where among women 0-23 months postpartum, 41% have an unmet need for spacing and 27% have an unmet need for limiting pregnancy.<sup>3</sup>

The postpartum period is a particularly important time to examine contraceptive use and unmet need as the World Health Organization (WHO) recommends waiting at least 24 months to conceive after the birth of a child to support best outcomes for both mother and child.<sup>4</sup>

During the postpartum period, women are more likely to interact with the health system, providing an important opportunity for health workers to discuss FP and offer contraceptive methods. However, despite these increased interactions, postpartum family planning (PPFP) use among women in Uganda is still relatively low, ranging from just 5% of women using modern contraceptives at two months postpartum to only 12% at six months postpartum.<sup>5</sup>

Men play an important role in decisions about contraceptive use and family size, yet they are often left out of education and outreach programs that primarily target women.<sup>6</sup> Engaging men effectively in FP programming that addresses their priorities, assumptions, and preferences, is an important component to increasing postpartum contraceptive uptake.

IntraHealth International, in partnership with ideas42, implemented the Scale-Up and Capacity Building in Behavioral Science to Improve the

Uptake of Family Planning and Reproductive Health Services (SupCap) project, funded by the William and Flora Hewlett Foundation, to address the challenges of PPFP uptake. We implemented the SupCap project within the USAID-funded Regional Health Integration to Enhance Services in Eastern Uganda (RHITES-E) Activity led by IntraHealth.

## APPROACH

SupCap employed a behavioral design process to address barriers women and men face in using contraception during the extended postpartum period (Figure 1 below).<sup>7</sup>

After **defining** our challenge as low PPFP uptake, we moved to the **diagnose** phase of the methodology where we conducted interviews with postpartum women, male partners of postpartum women, and health workers to better understand barriers to postpartum contraceptive use. Based on these interviews, we identified six behavioral barriers:

1. Couples typically do not discuss number or spacing of their children
2. Couples typically do not discuss whether to use FP or not
3. Couples underestimate the cost of having a child or overweigh the benefits
4. Couples think their current actions to avoid children are sufficient
5. Couples are not consistently prompted by health workers to consider FP
6. Couples fear health consequences of FP.

Based on these barriers and the scarcity of dedicated FP programming for men, we **designed** an intervention targeting male partners of postpartum women

Figure 1. Behavioral Design Methodology

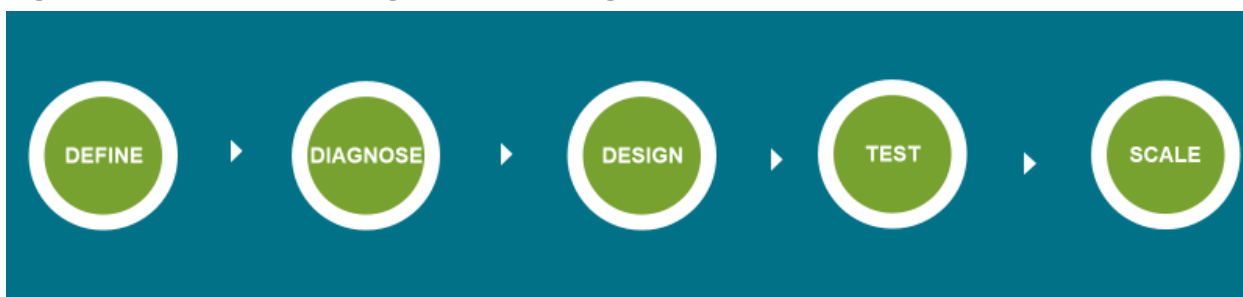




Figure 2. Child Spacing Planning Card

**We invite you to your nearby health facility for a child spacing session:**



**1. Ask your partner**

Do you want any more children?

Yes *If yes, in how many years? \_\_\_\_\_*

No



**2. Decide when to go to the health facility to learn more**

When will you go to the health facility to learn more?

Date: \_\_\_\_\_



**3. Ask a health worker about available child spacing methods**

Call the toll **free** hotline: 0800 200 600 if you have questions about child spacing.

**TOGETHER YOU CAN PLAN FOR A HEALTHY FAMILY!**

comprised of three components—an interactive game called “Together We Decide,” a child spacing planning card (Figure 2), and SMS messages. In developing the intervention, we focused on the following design objectives:

1. Reinforce costs—encourage men to consider all costs of having children (including monetary and health-related costs)
2. Elevate pregnancy risk perception—lead couples to reassess their likelihood of getting pregnant if they are not using modern contraception
3. Mitigate fears—address fears rooted in misconceptions about the health consequences of using modern contraception
4. Prompt joint decision-making—encourage couples to discuss childbearing and contraceptive options, equip them with the information they need, and reinforce that it’s a joint decision
5. Encourage clinic visits—motivate both men and women to visit health facilities to learn more about contraceptive methods
6. Facilitate health worker and client conversations—prompt health workers to consistently discuss contraceptive options with men and women.<sup>8</sup>

The goal of the intervention was to increase PFP use, couples’ communication, and knowledge about contraceptive methods. Male partners of postpartum women would play Together We

Decide in small groups facilitated by village health teams and receive a planning card to take home and discuss FP with their partners. Through the game, male partners would learn more about different contraceptive methods, better understand the short- and long-term financial implications of children, discuss FP with their partners, dispel myths and misconceptions about contraception, and make a plan to go to a health facility to receive additional information about FP. The intervention planned for postpartum women, male partners, and health workers to receive SMS messages over a period of several weeks with information about contraception, the benefits of FP, and reminders to health workers to speak with clients about FP.

### Test Phase

We tested the intervention through a quasi-experimental study in six districts in eastern Uganda from January-March 2020. There were three intervention districts (Kapchorwa, Kibuku, and Serere) and three control districts (Kween, Pallisa, and Amuria). Men in each of the intervention districts played between one and six sessions of the game and received a planning card. Male participants took baseline and endline surveys consisting of demographic questions and questions on knowledge, attitudes, and practices about contraceptive use. Due to COVID-19 restrictions, the endline survey was conducted via phone. Results from the SMS messages were not able to be retrieved and were not included in the analysis.

**Table 1. Test Phase Results**

OUTCOMES		Men (N)	Baseline (%)	Endline (%)	Endline-Baseline	Difference in Difference	p-value
Male decides on contraceptive use (%)	TREATED	583	44	19	-25	-13.48	0.06+
	CONTROL	98	46	35	-11		
Couple decides on contraceptive use (%)	TREATED	583	49	80	31	14.88	0.04*
	CONTROL	98	47	62	15		
Knows a modern method of contraception (%)	TREATED	583	95	99	4	3.61	0.13
	CONTROL	98	99	100	1		
Modern methods are a good choice to space children (%)	TREATED	583	85	99	14	13.39	0.00***
	CONTROL	98	97	98	1		
Uses a modern method of contraception (%)	TREATED	583	52	81	29	8.75	0.21
	CONTROL	98	53	73	20		

Note: Unadjusted results using original treatment assignment.  $p < 0.001^{***}$ ,  $p < 0.01^{**}$ ,  $p < 0.05^*$ ,  $p < 0.10^+$

We found evidence that the intervention led to improvements in knowledge and attitudes about modern contraceptive methods and joint decision-making. Men in the intervention group were less likely to say they were the sole decision-maker for contraceptive use in their household and more likely to say that the couple decides together on contraceptive use compared to men in the control group (Table 1). The biggest change between intervention and control groups was seen in attitudes about modern contraceptive methods. Men in the intervention group were more likely to say that modern methods are a good choice to space children compared to men in the control group, indicating a positive view and changed attitude about modern contraceptive methods (Table 1).

Contraceptive use increased among men in the intervention group (Table 1). This result was not statistically significant; however, since men's attitudes about modern contraceptives improved, we hypothesize this number may be lower due to couples not being able to get to a health facility due to COVID-19 lockdown policies.

### Scale-up Phase

Based on the positive results from the test phase, we moved to the final stage of the methodology

(scale). The project scaled two components of the intervention—the interactive game and the planning card—in all six study districts from October 2021-February 2022. To scale the intervention in a sustainable manner, the team conducted a training of trainers for district health officials on the intervention. These trainers in turn trained village health teams in each of their districts. Health workers collected child spacing planning cards from clients and noted counseling sessions received and which contraceptive methods (if any) were accepted. The total number of clients connected to methods may be higher than the project recorded due to clients forgetting their planning cards when visiting a health facility. Project staff calculated PFP contribution using the planning cards collected at health facilities and district health information system (DHIS2) data.

At the end of the five-month scale-up period the team:

- ▶ Conducted 4,618 game sessions, reaching 20,576 men
- ▶ Distributed 19,271 child spacing planning cards, 41% of which were returned to a health facility by a man, woman, or couple for counseling on FP
- ▶ Connected clients to 7,434 contraceptive methods
- ▶ Contributed to 61.5% of total PFP uptake in the six project districts

- ▶ Helped increase the range of methods clients chose, including a significant increase in permanent methods.

The intervention transitioned to district health teams in March 2022 for continued implementation. Districts developed sustainability plans during consultative sessions in February 2022 where they mapped out how they will continue to fund the intervention. Some of these methods include utilizing results-based financing and incorporating the intervention into health facility workplans through primary health care funding, 30% of which is allocated for health promotion. District officials were part of the decision-making team and the main implementers from the beginning of the project, which made for a smooth transition of responsibilities. Thanks to the strong evidence from both the test and scale-up phases, districts were convinced about the value of continuing to fund the intervention and decided to do so.

*"It [SupCap] educated members of the community, educated women, and educated fathers about the benefits of FP"*

– Dr. Odeke Francis, Serere District Health Officer

## WHAT WORKED

- ▶ A wide range of stakeholders were involved at every stage of the methodology. During the define, diagnose, and design phases community members were interviewed, consulted, and provided feedback on multiple iterations of the intervention design. Throughout each stage of the project, but particularly the test and scale phases, district stakeholders (e.g., health officials, health facility staff, subcounty leaders, religious leaders) were consulted and part of the decision-making process to ensure shared ownership and agreement about the intervention.
- ▶ Testing the intervention through a rigorous quasi-experimental study provided strong evidence that the intervention led to the desired changes and supported the decision to scale-up the intervention to all study districts and additional villages.
- ▶ Utilizing human-centered design principles resulted in an intervention that was relevant to the target community and produced a sustainable mechanism for continued implementation.
- ▶ The game was lighthearted and designed to be played in a friendly competitive atmosphere. Relaying information in this manner was a non-threatening way for men to become more comfortable with a sensitive topic.

## WHAT WE LEARNED

- ▶ Involve district officials early to support buy-in and continuous support.
- ▶ Involve all health workers at the facility. During the test phase of the project, only a few health workers at the facilities were oriented on the intervention. This caused some confusion at health facilities about what to do when people arrived with planning cards as not all health workers had been briefed or understood the intervention. During the scale-up phase, we made sure to conduct a separate health worker training and integrated their involvement as a main step for implementation.
- ▶ Several unanticipated gains emerged from the project:
  - ▷ Improved reporting in health facility FP registers thanks to training from the project
  - ▷ Decreased reports of gender-based violence in intervention districts due to improved couples' communication around contraceptive use, as reported by the health facility teams and district health officers
  - ▷ Increased demand for contraceptive methods, which led to contraceptive stockouts in some project districts
  - ▷ Increased results-based financing to districts, thanks to improvement in FP indicators.

# CONCLUSIONS

Encouraging FP use in the postpartum period is important to improve health outcomes for women and children. Men play an important role in family planning decision-making and engaging them effectively is a key component of increasing postpartum contraceptive uptake. Our intervention shows a new approach to reach men with FP programming that addresses their unique needs and encourages joint decision-making about their family's future. As results from our quasi-experimental study and scale-up show, specifically targeting male partners can increase couples' communication about contraception and FP and increase PPFPP uptake. Inclusion of men in FP research and programming should become more routine to support positive health outcomes for women and children.

Photo on page 1 by Esther Ruth Mbabazi, 2021

<sup>1</sup> Uganda Bureau of Statistics (UBOS) and ICF. 2018. Uganda Demographic and Health Survey 2016. Kampala, Uganda and Rockville, Maryland, USA: UBOS and ICF.

<sup>2</sup> Uganda Bureau of Statistics (UBOS) and ICF. 2018. Uganda Demographic and Health Survey 2016. Kampala, Uganda and Rockville, Maryland, USA: UBOS and ICF.

<sup>3</sup> Moore Z, Pfitzer A, Gubin R, et al. 2015. Missed opportunities for family planning: an analysis of pregnancy risk and contraceptive method use among postpartum women in 21 low- and middle- income countries. *Contraception*. 2015 Jul;92(1):31-9.

<sup>4</sup> USAID, ESD. HTSP 101: everything you want to know about healthy timing and spacing of pregnancy. [https://www.thecompassforsbc.org/sites/default/files/strengthening\\_tools/htsp101.pdf](https://www.thecompassforsbc.org/sites/default/files/strengthening_tools/htsp101.pdf). Accessed 8/4/2021.

<sup>5</sup> Track20. Opportunities for family planning programming in the postpartum period in Uganda. <http://www.track20.org/download/pdf/PPFP%20Opportunity%20Briefs/english/Uganda%20PPFP%20Opportunity%20Brief%202.pdf>. Feb. 2020. Accessed: 8/12/2021.

<sup>6</sup> Hardee K, Croce-Galis M, Gay J. 2017. Are men well served by family planning programs?. *Reproductive Health*. 2017 Jan;14(1):14.

<sup>7</sup> Datta S, Mullainathan S. 2014. Behavioral design: a new approach to development policy. *The Review of Income and Wealth*. 2014 Feb;60(1).

<sup>8</sup> ideas42, IntraHealth International. 2021. Supporting couples to make active, joint decisions about childbearing: an interactive game on family size, child spacing, and contraceptives in Uganda. <https://www.ideas42.org/wp-content/uploads/2021/06/i42-Supporting-Couples-to-Make-Active-Joint-Decisions-About-Child-Bearing.pdf>.

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