PREMISES AND RATIONALE OF CONTRACEPTIVE SERVICES ACCESSING IN SOUTHERN ETHIOPIA: A PHENOMENOLOGICAL EXPLORATION

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ABSTRACT

BACKGROUND: Despite the encouraging engagements of stakeholders in contraceptives provision in Ethiopia, there was paucity of information on service providers' and users' experiences about the premises for accessing services. Therefore, the study was conducted to explore service providers' and user's lived experiences under which premises the services are being given.

METHODS: Interpretative phenomenological qualitative methodology was employed to explore the lived experiences of contraceptive services stakeholders. Data were collected using focus group discussions and key informant interviews. Data were analyzed using an interpretive phenomenological analysis framework including phases of data immersion, transcribing, coding, theme development, and phenomenological interpretation through hermeneutic circle.

RESULTS: The study captured enabling context for contraceptive service provision and use from various rationales, organization, and expansion of contraceptive services to the community and households. The findings indicated that contraceptive service provision from the demographic and socio-economic perspectives was understood adequately all in the positional hierarchies, but the human rights-based rationale was less obvious, except for higher level health leaders.

CONCLUSION: The study concludes that the bigger picture premise for contraceptive services provision, the human right approach, remained elusive as one moves down the hierarchy in health care organizations. On the other hand, the demographic, economic, and health rationales are more obvious. Hence, the study recommends the disconnect in the broader premises of providing contraceptive services (the human rights approach) must properly be communicated to the lower-level stakeholders.

KEY WORDS: Demography, Economy, Human rights, Contraception, Phenomenology, Rationale

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INTRODUCTION

Modern contraceptive services are practiced primarily based on demographic rational[1]. Currently, the program comprises the health and human rights rationale, and practiced in many western countries [1]. The latter is strongly recommended by the WHO [2].

Sexual and reproductive rights are inalienable human rights, inseparable from other basic rights [3]. Sexual and reproductive rights can be defined in terms of power and resources: the power to make informed decisions over one's own fertility, procreation and childcare, and sexual activity, as well as the resources to carry out those decisions safely and effectively [4]. The link between reproductive rights and women's empowerment and the role of contraceptive utilization is obvious [5]. The ability of women to control their sexuality and fertility through proper use of contraceptives is the cornerstone to ensuring other aspects of women's and human rights [6,7].

Although women's rights in relation to contraceptive use have been invoked since the early 1900s, this rationale remained obscure due to lack of public attention. Strong global women's movements rising against the overemphasis of overpopulation on the issue of contraceptive services have made remarkable progress over the past two decades in re-situating contraceptive provision as part of the broader issue of women's rights and desires [8]. These movements assert that any policy and program geared towards contraceptive services provision should consider the social justice and individual rights in all social and economic situations [9-11].

The International Conference on Population Development (ICPD) program stressed that women's empowerment was one of the strategies identified as critical to addressing the population and development problems in achieving the proposed goals [12]. Since the release of the ICPD, the issue of contraceptive provision has recognized women's rights as reproductive rights, and as being included in all reproductive health components [12].

In Ethiopia, a significant amount of research has been conducted in relation to contraceptive use. Some of these studies addressed the benefits of contraceptive use related to demographics and health benefits [9]. There is a dearth of information about the benefits of contraceptive use from the perspectives of human rights/women's rights. The government of Ethiopia has realized the importance of providing family planning from the perspective of human/women's rights and designed a new family planning strategy emphasizing these rights and has incorporated similar considerations in the health extension program. This study was conducted with the aim of investigating the lived experiences of Ethiopian women using contraceptive, as well as service providers and managers about the broad perspectives of providing contraceptive services. It purports that service provision from a human right- based approach would further enhance the accessibility, acceptability, and sustainable use of service to ensure the multidimensional benefits of contraceptive services.

METHODS

The Research Context

This study was conducted from September 2013 until May 2014 in three districts of Sidama Zone. Sidama Zone is one of the thirteen zones in the former Southern Nations Nationalities and People's Regional state (SNNPR) of Ethiopia. The Zone is bordered with Oromia Regional state in the southeast, east and north, Gedeo zone in the south and with Wolaita Zone in the west [13].

Study Design

The study employed an interpretive phenomenological qualitative methodology for understanding the lives of the study participants. It focused on describing the meanings given by the individuals and how these meanings influence the access to the services [14]. The study aims to explore the life experiences of study participants related to the premises of accessing contraceptive services [15].

Data collection

Focus group discussions (FGDs) and key informant

interviews were used. Three female research assistants with educational and professional experience conducted the interviews and discussions. A purposive sampling method was used to include well-informed participants [16].

A total of 82 women of reproductive age group participated in the focus group discussions. Eighteen key informants were involved in the interview based on the designated position they hold in their respective institution (Additional file 1). Semi-structured interview guides were utilized for the interviews and the discussions. Participants were encouraged to speak up about their experiences through diligent probing [17].

Once participants took their seats, the health extension worker introduced them to the research team. Permission to audiotape and to take notes was secured to document the discussion. The researcher moderated the discussion session and the research assistant translated to the women. Care was taken to involve all participants equally so each could discuss their lived experiences in a session of 60-90 minutes.

All the key informants' interviews were conducted individually in the informant's office. Copies of study support and ethical clearance letters were presented to the informants after establishing rapport. After making sure that the informant had read the letters, the research team asked permission to continue and gave the informant a consent form to read and sign. Once the research team obtained a final signed consent form from the key informant, the interview was conducted.

In accordance with the procedure of the qualitative study and the interpretive phenomenological approach, discussion was carried out thoroughly based on the study guide and opportunities to probe more issues as they emerged. The interviews lasted from 60 to 90 minutes and the research team made sure the entire interview was documented both in the form of an audio recording and notebooks 18.

Data analysis

Analysis was done using the guiding principle of interpretive phenomenological analysis (IPA) [19]. An adapted flow diagram from the IPA was used to guide the analysis (Additional file 2). All the audiotaped materials were transcribed verbatim, first in Amharic then translated to English and then back to Amharic by a professional linguist (additional file 3-5). The principal investigator checked for consistency in every step. Key informants were given the chance to comment on summary transcripts. Field notes were organized under the guiding research questions. The principal researcher made several readings on the transcripts to reach data immersion. Margin notes and descriptive coding were then completed for all the materials. Data reduction was done in a stepby-step approach, beginning with the transcripts, followed by descriptive coding, and then distilling this material into themes by bringing similar ideas and concepts together. Themes were identified using side notes and were guided by the research questions. The analysis process made use of the idea of a hermeneutic circle; in brief, the back-and-forth iterative linking of data from both perspectives of the researcher and study participants [19].

Quality assurance or trustworthiness was done in line with the qualitative data quality assurance steps: credibility, transferability, dependability, and conformability [19]. It was carried out by: 1) presenting the summary of transcripts to the study participants to give them an opportunity for further comment; 2) reviewing of the preliminary findings to ensure the early findings reflect what they know and experienced; 3) sharing the preliminary summary findings with the health leaders and service providers to check interpretations.

RESULT

The study finding is presented under the respective questions relating to the lived experiences of the health managers, service providers, and service users about the premises of providing contraceptive services in the study environs. Experiences of the study participants about the broad premises of providing contraceptive service as one of the enabling situations for service provision: Our interest was to learn the broad premises on which

the contraceptive service is delivered to clients. Discussions with key informants revealed that contraceptive service is being given to improve the health status of mothers and children and to harmonize the number of children with one's economic capacity. The key informants mentioned the health and economic rationale as the major reason and this can be understood from the following quotes given at the levels of managerial and service provision: One of the goals is improving the health status of mothers which further contributes to the health of the family, community, and the country at large. Ethiopia, as a developing nation, has many sociodevelopmental challenges. For example, the nation has nearly eighty percent of its population live in the rural area where farmland size is depleting over time. This means that the rural land ratio to the population is significantly reduced and thus agricultural productivity remains strained. It is obvious that the district has no means to expand the land size. Some of the challenges are related to unregulated fertility which could have been normalized through providing contraceptive services to our clients (Gurumu, a district manager aged 27). Furthermore, the health and economic rationale/ benefits were well expressed by the women who use services. The study revealed that the livelihood changes of most service users were positive in comparison to pre-contraceptive use period. The following excerpt taken from focus group discussion and supports this claim: From the time I began using contraceptive service, I started to space pregnancy for five years at least. I got adequate time to handle my children properly, breast feed adequately, and grow well. My health status is improved, and I gained strength. I reached to state of deciding when and how to get pregnant in connection to my health and economic status (Dangure, used the service for five years and aged 28).

On the other hand, health managers at higher levels have expressed the human rights rationale for providing contraceptive service. One of the informants at the higher level of health administration expressed this as follows: The main reason for provision of contraceptive service to the citizens in our Country is based on the national constitution which indicates health as the right of the people. The constitution enshrines that every woman has the right to decide on the number and timing of bearing children as she wants. Reproductive rights are basic human rights. Therefore, citizens have the right to get proper knowledge and services related to reproductive health including contraceptive service. The other one is related to the desire of couples to limit or space the number of children they want to have (Markos one of the higher-level leaders aged 32). Furthermore, discussions with key informants clearly reveals that the economic or demographic and health rationale is being given the major emphasis in the provision of services. The informants stated that Ethiopia as a developing country strongly needs to regulate the population growth in relation to its socio-economic status. Similarly, the study area is characterized by such a perspective, with the aforementioned rationales being topmost in the agenda. This idea is further elaborated by one of the key informants and top health managers at the regional level: The demographic rationale of contraceptive service for a nation like ours is mandatory and no negotiation is needed on this matter. This is not only from the global or national perspectives but if you go to the family level, they tell you about it. You can easily observe a family postponing pregnancy for long time even without having one child. When we ask them why, they tell us the challenges they anticipate in up bringing them related to demographic and economic problems.

To demonstrate the progress in respect to socioeconomic dimensions, the country must harmonize the population growth with the economic growth. However, there is a disconnect in the comprehensive understanding regarding contraceptive service provision from the human rights rationale, and this affects the provision of contraceptive services from the premises of the ICPD agreed plan of action and proliferation of the

human rights-based approach. The study revealed that most women did not understand that their challenges are related to issue of human rights. This is demonstrated by the quote from one of the FGD discussants in the following way: We receive the services on our respective appointment dates without any worries and return home to do our work. In the grace of our Lord and due to the commitment of the government, now we are freed from challenges related to mistimed and unplanned pregnancies and their related burdens (Balesse, a 25-year-old woman in the sixth grade).

DISCUSSION

The study examined the broad premise of contraceptive service access from historical trajectories and current trends. The level of emphasis given to contraceptive service and the underlying rationales differ across the world despite the global consensus [2]. In relation to this, the study examined the rationale governing the contraceptive service provision in the study area.

Service providers and health leaders revealed different experiences about the ultimate rationale for contraceptive service accessing. Health leaders at higher levels clearly internalized the broad premises of providing contraceptive services. Their experiences showed that Ethiopia has endorsed the rights rationale as the backbone for reproductive health service provision.

The leaders expressed that a health issue is a human rights issue [2], to which Ethiopia reveals its commitment. It was enforced by including the health issue as part of human right issue in the constitution. The revised reproductive health strategy of the country confirms that provision of contraceptive services is part of reproductive health under the rights rationale and is a priority of the country. In this case, the experience of higher-level leaders matches with the international consensus. Ensuring reproductive rights through reproductive health service provision supports the attainment of the highest possible level of reproductive outcomes [20].

However, the study has uncovered lack of consistency of the phenomenon, the rationale from the perspectives of lower lever participants including service users. When one goes down to the operational hierarchy, it was easy to hear the demographic, economic, and health rationales automatically, but the issue of the rights rationale was a gray area. District managers emphasized the demographic and economic rationale when considering their district's socio-economic context. They expressed the seriousness of poverty, the everdiminishing land size, and the loss of agricultural productivity as the reason for their emphasis on the demographic and economic rationale. They ardently expressed that the economic and demographic rationale cannot be overlooked [21,22].

The experience of the lower-level health managers and service providers is commensurate to the dominant demographic and economic rationale, despite 20 years of advocacy related to other rationales, the rights-based approach. The study ascertained that health leaders and health service providers strongly emphasized economic and demographic rationales more readily than others. Women's experiences also revealed that the primary purpose for which they are using contraceptive services is related to economic and health issues [23]

The health rationale is another area that health professionals associated with. They expressed their experiences and attitudes in this regard, stating that contraceptive service is lifesaving for both mothers and children. Women's experiences also substantiated this, as their health status has improved due to contraceptives use. The study disclosed women's feeling that the government offers contraceptive services as a measure of goodwill and blessing, but that they do not see the service as an inherent right the government is obligated to provide. This may be due to the long-standing reproductive health and livelihood challenges they had faced and their low level of awareness of rights and privileges to which they are entitled. The perspectives in this study are distant from those of the ICPD declaration and global

agreements that nations have obligation to provide access to reproductive health services, including family planning, to their citizens [4,9].

It can further be argued that the reproductive health rationale (human rights rationale) for providing contraceptive services is not well communicated and that there is inadequate emphasis on the issue. It can be argued that such undertakings affect the rights of women to make decisions regarding their reproductive health. Moreover, the information gap that existed in the health hierarchy demonstrates that the level of understanding towards rights issues is inadequate. This lack of attention to contraceptive use as a right may negatively influence the rapid expansion of services [9]. It can be substantiated that a service that "respects, protects and fulfills" reproductive rights enables sustainable use by reducing the power gaps that exists between the service providers and the women[2].

Whereas contraceptive service has a wide spectrum of benefits, the narrow focus of service only from demographic/economic and health premises limits not only the rapid expansion of service (accessibility & availability), but also the quality and sustainability of service, hence the outcome and impact [2]. If contraceptive provision program is established from a human rights perspective across all the service providing outlets, the service will further ensure rapid attainment of global and national development goals by putting women at the center [2]. The human rights approach offers a broad lens for action by envisioning the changes in political, economic, social, cultural, and individual spheres. Moreover, providing contraceptive services from rights premises fundamentally ensures the notion that a service should respect, protect, and fulfill the human rights [24]

It can be argued that the 'disconnect' between the higher-level leaders and grass root level service providers in utilizing the rights premises is the crucial area that need more attention. The frontline health workers acquaintance with the rights perspective is a key in reaching to husbands and elders [25]. Establishing a notion that contraceptive service provision must consider women as an end but not only as a means is fundamental to ensure the reproductive rights of women 18, 44. The observed disconnect among the service leaders and providers towards human rights premises is a deviation from the international agreement for contraceptive service provision, in which the rights approach is embedded. The WHO guideline clearly stipulates that reproductive services that respect, protect, and fulfill human rights exhibit better health outcomes [2].

Strengths and limitations

The limitations of the study may be the inability to include men in the FGD. The delimitation of this study is explained as such that the study was carried out with the intention to explore the experiences of women contraceptive service users, service providers and health managers in the Hawassa University research villages established with the intention to observe the impact of university-based research in knowledge generation, technology transfer, and the livelihood of the residents.

CONCLUSION AND RECOMMENDATIONS

Based on the findings of this study it can be concluded that despite twenty years of advocacy for the right based approach for reproductive health service provision, the bigger picture and rationale for providing contraceptive services, the human right approach, remained elusive/unclear as one moves down to the hierarchy in health care organizations including the service users.

Recommendations

The study recommends the followings for the sustainable contraceptive use:

1. A clear acquaintance to the rights-based reproductive health service delivery approach is needed by the frontline health care workers. Strategy should be designed to train, monitor, and evaluate whether the reproductive services are being given from the human rights perspective.
2. Service users ought to be made aware that it is their right to receive contraceptive services through rights-based education.

3. Deeper questions also remain that deserve consideration. Why has the rights approach to contraceptive service remained obscure?

Other rationales for contraceptive use have been straightforward, translating readily to the practices of service providers; does the lack of uptake and understanding of the rights approach relate to the underlying socio-political context? If so, in what manner?

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List of Abbreviation

WHO: World Health Organization; PHC: Primary Health Care; MOH: Ministry of Health; HEP: Health Extension Program; HEW: Health Extension Worker; SNNPRG: South Nation, Nationalities and People's Regional Government; FGD: Focus Group Discussion; IPA: Interpretive Phenomenological Analysis; ICPD: International Conference on Population Development.

DECLARATION

Ethical considerations

Ethical clearance was obtained from the University of Saskatchewan Research Ethical Review Board in Canada and Hawassa University Institutional Review Board in Ethiopia. Signed consent forms were obtained from the study participants and participants were assured rights to participate or withdraw from the study. Anonymity of the direct words of the participants is maintained by using the pseudonyms. The quotes from key informants were presented without indicating the identity of the individual. Study participants were informed about communication of the study finding in various meetings, workshops and publications and verbal consents were obtained.

Availability of Data and Materials

The data for this study is available in the form of transcripts. All the three sources' transcripts are attached as supporting documents.

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COMPETING INTEREST

It was the efforts of all authors primarily dedicated for academic purpose. The financial supports from both universities were in support of a PhD study. Hence, there were no competing interests either from the funding sources or the authors.

AUTHORS' CONTRIBUTION

AA was responsible for conducting data collection, analysis and the write up. LH was responsible for revising transcription, analysis, editing and supervising all steps. MM was involved in designing the study, manuscript preparation, editing of the manuscript.

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