Title: Negotiating the user journey towards contraceptive self-empowerment: A case for DMPA-SC self-injection.

Background

The risks associated with each pregnancy is carried almost entirely by a woman, however the decision about whether and when to get pregnant is a subject that several others contend with her to make. Partners, friends service providers and society hold various levels of influence over a client's decision to use contraception. Factors associated with a woman's decision not to use contraception include partner's desire for more children as well as myths and misconceptions often associated with religious and ethnic values, beliefs, and norms (NDHS, 2018). She is in constant negotiation with several influences including her partner, family, friends, health provider and the community for her autonomy.

The need to amplify the user's voice above all others is even more imperative in Nigeria considering that the lifetime risk of dying during pregnancy, childbirth, postpartum or post-abortion is 1 in 22, in contrast to the lifetime risk 1 in 4900 in developed countries (Beatrice, 2020). As many as 512 women die from pregnancy out of every 100,000 women of reproductive age in Nigeria and mortality amongst children whose mothers died were much than those whose fathers died (National Academies of Sciences, Engineering, and Medicine {NASEM}, 2020). Similarly, malnourishment was found to be more common amongst children who lost their mothers that those who lost their fathers or with both parents living (NASEM, 200).

The need to support a woman to take well informed and voluntary decisions in her best interest is one that requires careful consideration of these influences, their dynamics and contexts, as well as opportunities to address them. The World Health Organization (2019) defines self-care as the capacity of individuals and groups to take control of their health and its determinants with or without the support of a healthcare provider. It recommends DMPA-SC Self-injection (SI) as one of its new self-care approaches for universal access to high-quality family planning services. DMPA-SC self-injection has the potential to create opportunities for women to take control of their reproductive health, particularly where there are barriers to facility-based services. For many, each journey to the health facility is one that is fraught with the concern of being discovered, therefore the convenience of self-administration at home, anticipated to be a benefit also could contend with her capacity for covert use.

Methodology

The Delivering Innovations in Self-Care (DISC) project supports women to take more control over their sexual and reproductive health (SRH) by scaling up quality self-care options starting with self-inject DMPA-SC services. To obtain insight into the influences that interfere with a woman's capacity to make contraceptive choices independently, the project conducted two intensive rounds of cross-sectional qualitative data collection. A convenience sampling of respondents was used and data collected was analyzed using a codebook and Atlas-TI. The research team members came together for participatory analysis workshop to explore and interpret emergent themes.

Findings

Independent users

Findings indicate that women are increasingly finding their voice. According to client, "A woman should make the decision because we know ourselves better. If your husband refuses, you should find a way to adopt a method…I don't need any permission. I need the family planning, if I don't take the method,

something can happen.” (Client can’t seem to bear the thought of getting pregnant now). Amongst women who act independently are those that do it for health reasons – for example in compliance with a doctor’s advice to defer pregnancy because of a previous caesarean section. Others do it to prevent a deterioration of their economic situation and to achieve personal ambitions (continue school or to be better positioned to get a job).

Women who hold independent decision-making power still prefer to act in partnership and share decision making power with their male partners. They will only go ahead and take up contraception services independently if they don’t have the consent of their husband. According to a client “It is good for both husband and wife to determine whether to use, not just the woman only”. Another says she sat with her husband to discuss her plans to obtain contraception. She did this to prevent being blamed if any problems arise later. According to her, “two heads are better than one”.

Partner influence

Male partners’ influence on women’s use of family planning and self-inject was most dominant. There were examples of men’s support for women’s use of contraception to prevent unintended pregnancy, as well as men withholding support for women’s use. Overt male support occurred openly and actively – partner’s patronage facilitated using personal resources. Some even accompanied their wives to receive the method and played a major role in reminding them about re-injection dates. One client said “my husband knows that I am using family planning. He is the one that led me to come and do family planning because he does not want another baby”.

Male support occurred mostly for economic reasons and to prevent the repeat of an un-favorable pregnancy outcome. Other men are motivated by their dual desire to resume sexual intercourse with their wives after she has taken delivery and prevent pregnancy. Male involvement is also affected by a man’s sense of personal obligation. One referred to time as a major factor limiting male involvement as many husbands were too busy with other responsibilities – “many had to be at work at the time of hospital visits”. Conversely, some men presented as silent dissenters who didn’t discourage contraceptive uptake but project an uncooperative demeanor and withdrew financial assistance.

Other men outrightly deny their partners from obtaining contraceptive services and their partners cede this sexual and reproductive health right without objection. A client said, “If my husband doesn’t allow me, then I won’t come”. A client stated that “her husband has power over [her] as she runs all her decisions through him as her religion requires. She only does things on her own if they do not go against the religion”.

Provider influence

Providers seem to have a strong presence, are well respected and looked up to by the clients. Information given by the provider is accepted and, in many cases, clients cede power to providers to shape their SI user journey. In some facilities for instance, providers insist that clients come with their husband and will not administer contraception if husband doesn’t participate and consent. One client said, “if her husband had not accompanied her, she (the provider) would not have allowed her do FP even though provider knows she has six children”. Other providers encourage independent use. A provider stated that “some clients say they want to go and get permission from their husbands, but I convince them that they can make their own decision, and this will help them avoid pregnancy”.

A provider's influence on a client's decision to self-inject is reinforced by their biases and concerns. Common concerns include the fear of being less relevant within the context of selfcare. Others are concerned about clients' capacity to remember re-injection dates and the risk of injection abscess.

Most providers understand the concept of informed consent even if they don't practice it. Many claim to allow clients to choose whatever method they want by themselves, however for many providers, counseling is prescriptive. Once the provider perceives the client's contraceptive needs (often based on number & future need of children), they decide on method client should take without accompanying full, free, and informed counselling about other methods. Some providers will also only counsel a client about the method she has in mind, and not provide information about other methods. Even when information is given, it is not robust enough to inform decision making.

Peer influence

During group education at the health facility, some clients are reluctant to talk, and others don't want people to know about their intention to initiate FP. Some are distracted by the presence of peers and do not pay attention to FP information being provided. A few clients, however, are motivated to seek FP services because of testimony or interest expressed by peers.

Societal myths and misconceptions

A woman's decision to initiate family planning is affected by myths and misconceptions, many of which have cultural and religious origins. According to a client, her father-in-law says, "if you don't bring out all the children in your system, you will be sick". He even attributes the waist pain the client occasionally suffers to contraception intake. Others believe the use of FP makes people promiscuous, causes fibroid and that the amenorrhea experienced as a side effect of FP use indicates the "accumulation of blood in the womb".

Some tribes are known for their reluctance to use FP and often associate stigma with the pursuit of FP services. According to a client, "my husband does not know I am using FP. He does not believe in it although he is educated. He is from a tribe known to have a lot of children and I feel I am having children too fast and not able to get a job which I need to care for the children".

Media

Findings reveal a growing trend in the influence of social media on FP uptake. A client said she gets a lot of her family planning information on a women forum on Facebook where people share experiences and views about their sexual and reproductive health and family planning. She was referred to the platform by a friend and has since continued to frequent the platform.

Discussion

Several women have had to relinquish their rights to obtain family planning service to the influence of a male partner, provider, peer, society, and media even though she carries all the risks of pregnancy. Increasing awareness of her contraceptive options and the growing need to preserve her health and financial welfare is gradually empowering with the capacity to negotiate the barriers to her contraceptive user journey.

Self-care interventions offer promising and exciting new approaches for self-empowerment and independence in the contraceptive user journey. Many first-time users experience a sense of empowerment after successfully injecting for the first time. One client said in exhilaration after self-injecting "I feel like

a doctor!”. This feeling of empowerment initiates the process of self-discovery and agency and strengthens her resolve to take independent decisions in her best interest.

The opportunity to fully actualize this sense of empowerment can reinforced by her capacity to take home and continue to self-inject on her own and within the comfort of her habitation. This opportunity is often unrealized in social contexts that are unsupportive of the use of family planning resulting in covert use. Covert users would therefore rather not take the commodity home for fear of being discovered. Conversely, the opportunity for self-injection of DMPA-SC reinforces a women’s independence in contexts that are not overtly disagreeable.

Conclusion

Although voluntary self-injection of DMPA-SC increases choice, reduces barriers to accessing Sexual and Reproductive Health (SRH) services and a provides major opportunity for self-empowerment and agency, social influences have limited the realization of its full benefit. It therefore recommends context specific considerations required to support overt and covert user’s access to these benefits.

References

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