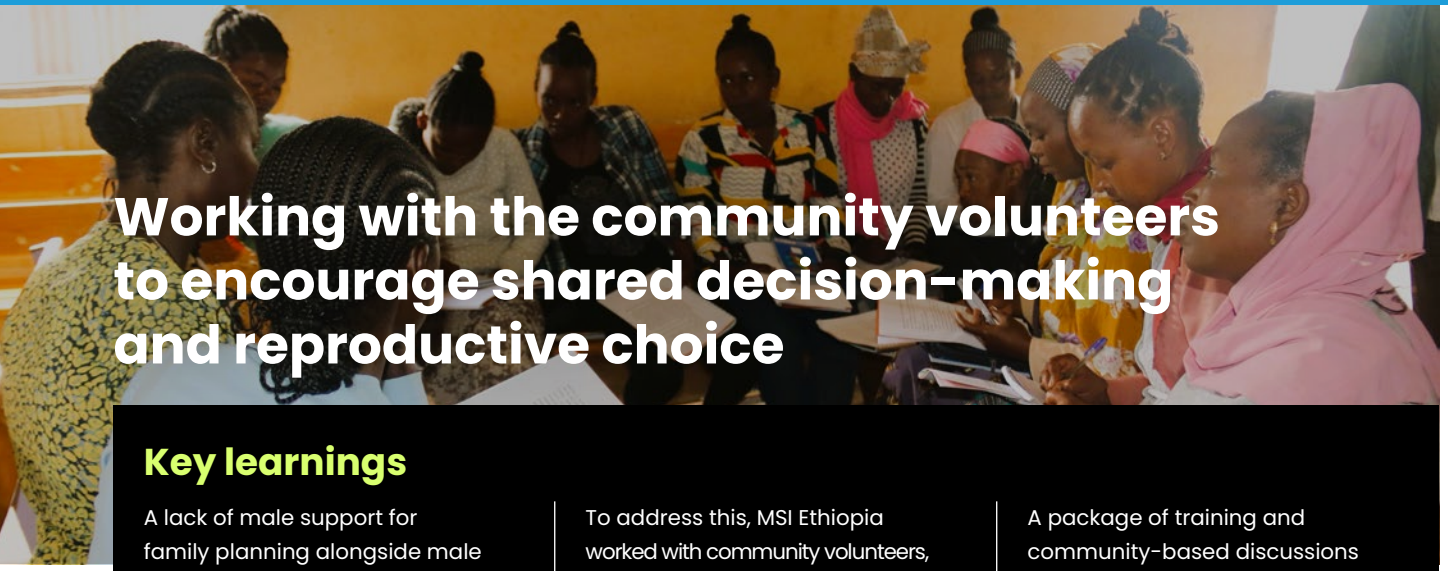


Working with the community volunteers to encourage shared decision-making and reproductive choice

Key learnings

A lack of male support for family planning alongside male dominance of the household and family decisions is a key barrier to sexual and reproductive health and rights for women and girls in rural Ethiopia.

To address this, MSI Ethiopia worked with community volunteers, known in the country as the Ethiopian Health Development Army and local agriculture groups to address the barriers related to gender and social norms affecting women and girls' sexual and reproductive healthcare.

A package of training and community-based discussions was able to successfully encourage inter-partner communication about reproductive healthcare and joint decision-making.

The challenge

Gender norms as a barrier

14M

The number of women in Ethiopia with a potential demand for contraception.

29%

The modern contraceptive prevalence rate among all women. Many women still lack the power to make their own reproductive choices.

4 in 10

Women in a relationship in Ethiopia who make their own decisions about their sexual and reproductive health (SGD indicator 5.6.1).

Gender norms regarding the household decision-making are likely a key barrier to many women being able to exercise reproductive choice and access contraception.

What we did

Partnering with Ethiopia health development armies

The MSI Ethiopia team used a participatory design process to develop a set of training and activities for use with frontline teams and community volunteers, including health extension workers, health development army members and local leaders.

The package included a series of trainings, community-based discussions and activities to be run with existing men's and women's groups separately, as well as monthly dialogues bringing men, women, and local leaders together. Values clarification and attitudes transformation workshops were held with local leaders to encourage support for and engagement with the pilot activities. Training on inclusive healthcare was provided for the health extension workers and healthcare workers at the government facilities in the pilot locations.

The pilot took place in the Gamo Zone Gezegofa Woreda, southern Ethiopia, and covered 16 Kebeles (wards). The Zonal and Woreda bureaus for health, women and child affairs and the finance bureau were engaged and a Memorandum of Understanding supporting the pilot was established. Pilot activities reached approximately 400 male development army participants (25 participants per group, across the 16 Kebeles) and the same for the female development army participants. The MSI Ethiopia team trained 40 healthcare workers, 35 health extension workers and engaged 30 traditional and religious leaders across the pilot locations.

Following six months of pilot activities, in April to May 2024 a mixed method pilot evaluation sought feedback from a sample of the men and women participating in the pilot activities (n=736) as well as a small number of in-depth interviews (IDIs = 8) and focus group discussions (FGDs = 4) with various profiles of pilot participants and stakeholders. These results were compared to a rapid baseline captured among a smaller sample of pilot participants (n=91).

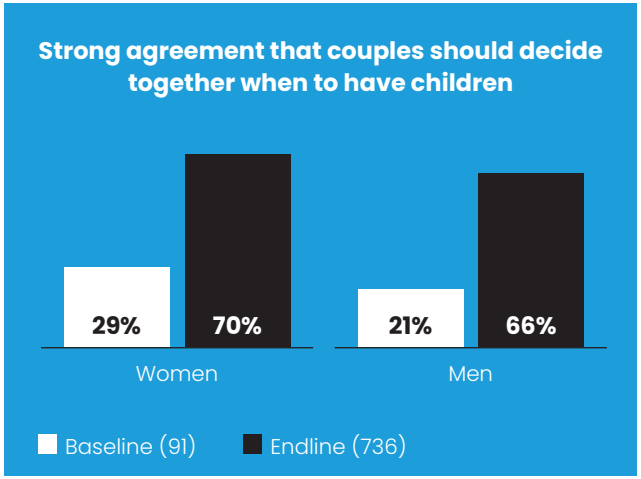
What we found

Couples communication and decision-making dynamics

Results suggest that the pilot was effective at encouraging couples' communication around family planning. This was both a focus of the themes of the pilot sessions but also woven into the participatory approach taken by the pilot activities, through the inclusion of joint dialogues involving the men women of the health development army.

At the end of the pilot, more than 8 out of 10 (82%) of all those participating in the pilot's community-based activities had discussed family planning with their spouse during the six months prior. This was much higher than the indicative results collected at baseline, which suggested only 4% had been discussing family planning.

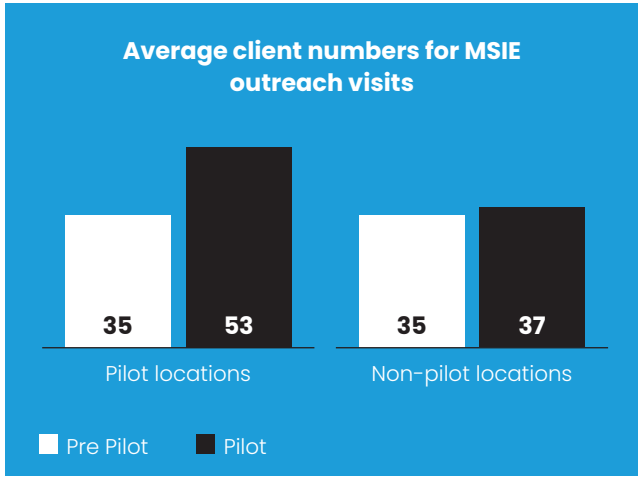
There were significant increases in strong agreement that couples should decide together when to have children among both male and female pilot participants.



Increased access to sexual and reproductive healthcare services

Couples' communication and joint-decisions prompted by pilot participation likely contributed to an increase in local health facility visits for family planning among women participants (from 16% to 43%). A quarter (25%) of male participants had also visited a health facility for contraception, the majority presumably with their wives. Overall family planning uptake among women participants post-pilot was high at 92% (compared to 37% in Ethiopia for married women in 2023 - source: Track20). More than eight out of 10 had opted for long-acting reversible contraception (73% implants). Participants also reported positive healthcare experiences: 81% rated the health facility they visited a nine out of ten or higher.

The MSI Ethiopia mobile outreach teams visiting the pilot locations also saw an increase of 51% in the numbers of clients served during the pilot period (compared to no change in non-pilot locations).



"Before the training people in our kebele did not accept family planning services. But now, the condition is reversed."

Kebele leader

What this means

Recommendations

Evaluation findings support existing evidence suggesting **the importance of engaging men and women's groups separately on SRHR and gender, as well as in mixed sessions.** The combination of the men's and women's sessions, as well as joint dialogues bringing both sexes together (alongside the participation of local leaders), appears to have worked well, and future activities should replicate this.

The themes included in the pilot package were clearly relevant and appreciated by participants, in particular, the general sexual and reproductive healthcare information, exploration of shared decision-making and the household division of labour. **Session content could be easily expanded to look in more depth at key issues, or to include further issues affected by gender norms.**

Leveraging the health development army and existing group structures was an effective way to spread key messages and start to address gender norms. Results suggest however that some participants were already positive about key themes covered in the activities.

Future activities should consider how to further leverage the health development army volunteers as positive role models, to ensure the maximum impact on social and gender norms at the community level (and the behaviours they impact).

While the training provided for health care workers and community-based actors was sufficient to support them to successfully deliver the package of pilot activities, feedback suggests that **further training and support would be required if the same are to deliver long term impact on complex issues related to SRHR and gender norms, particularly sexual and gender-based violence.**

Next steps

MSI Ethiopia will use these learnings to refine the pilot package, before looking for opportunities to scale these activities in Ethiopia and to adapt the resources for use in similar contexts where engaging men to encourage shared decision-making is a priority.

> "This project has created a structure and system that we could use, and this system will be functional even after the phase-out of this MSI project...The idea of the GESI project is so comprehensive. The project is not to resolve one issue alone; rather, it solves more than one community problem at a time."
>
> **Key informant, zonal health bureau**

More information

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