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MEDICAL BARRIERS TO FAMILY PLANNING SERVICES: A SECONDARY ANALYSIS OF SITUATION ANALYSES IN THREE WEST AFRICAN COUNTRIES

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INTRODUCTION

Improving access to high quality care in family planning has been a priority for many organizations and programs involved in reproductive health and family planning. A variety of strategies have been implemented, including: ensuring that client' perspectives are taken into account in the planning, management and evaluation of services; promoting the widest availability of different contraceptive methods so that people may select what is most appropriate to their needs and circumstances; and ensuring that contraceptive counseling and service delivery are based on updated eligibility criteria that are supported by a scientific rationale.[1]

Women may face barriers to obtaining contraceptives when a provider is not trained in updated eligibility criteria or does not support providing contraceptives to women in particular circumstances. In order to assist countries in updating their medical guidelines on family planning, the Reproductive Health program of the World Health Organization convened two scientific expert group meetings in March 1994 and May 1995 and prepared a set of guidelines for providers ("Improving Access to Quality Care in Family Planning: Medical Eligibility Criteria for Contraceptive Use", 1996).[1]

In order for a country to begin implementing these guidelines, it is useful to know what criteria providers currently use in providing family planning and what percentage of providers provide "barrier-free" family planning services. Through analyzing provider interviews on three situation analyses in West Africa, this analysis will attempt to describe current age, parity, marital status, and spousal consent barriers to family planning as defined by WHO's guidelines.

THE SITUATION ANALYSIS APPROACH

In 1989, phase I of the Africa Operations/Technical Assistance Project, administered by the Population Council and financed by USAID, developed a new approach to operations research called Situation Analysis. A Situation Analysis study involves the systematic collection of data at the level of the SDP, among a representative sample or census of SDPs. The information collected concerns the SDP's infrastructure,

staff, management, and quality of services. Two overall objectives of a Situation Analysis include describing the functioning and quality of FP services and analyzing the relationship between sub-system functioning and the quality of services. The five standard instruments of a Situation Analysis are: inventory of facilities and equipment, observation of the interaction between provider and client, FP client interview, MCH client interview, provider interview, and manager interview.

DESCRIPTION OF ANALYSIS/METHODOLOGY

This paper describes a secondary analysis of questions related to medical barriers contained in the provider interview module of the Burkina Faso (1995), Senegal (1995), and Ghana (1993) Situation Analyses. Providers were asked if they applied five specific criteria in providing a particular family planning method: minimum age, maximum age, minimum number of children, marital status, and spousal consent. Each of these barriers is described with respect to combined oral contraceptives, condoms, IUDs, injectables, and female sterilization, and are only considered among facilities that specifically offer the method. Norplant and vasectomy are nearly non-existent in each of the three Situation Analyses, and are therefore not included in this study

Age and Parity Barriers

Age and parity barriers are defined using the WHO guidelines. These guidelines provide both age and parity-based recommendations for each of the five selected methods within two different categories[1].

1. A condition for which there is no restriction for the use of the contraceptive method.
2. A condition where the advantages of using the method generally outweigh the theoretical or proven risks.

This analysis defines an age or parity barrier according to the **first category only**. For example, providers who do not provide IUDs to nulliparous women under the age of 20 are not considered to impose a barrier, despite the fact that only theoretical risks exist in providing IUDs to these women and the benefits may outweigh the risks. However, in this analysis, providers who do provide IUDs to this group are not "penalized" as imposing a barrier. Providers may be likely to overstate their eligibility criteria due to interview bias (they may be more hesitant to report that they provide family planning to unmarried women, for example, or they may report theoretical criteria which they do not consistently apply in practice); therefore, this analysis uses the more conservative approach in defining an age and parity barrier.

The following clinical guidelines were applied in this analysis Any age or parity eligibility criteria which fall above the minimum or below the maximum recommended

age, or above the minimum parity recommendations are considered barriers to family planning:

Combined Oral Contraceptives:

Age: menarche to 39 years. Because age at menarche is defined individually, no minimum age requirements are appropriate. The risk of cardiovascular disease increases with age and may also increase with COC use; providers who gave maximum age criteria greater than 39 were not considered to impose a barrier

Parity: no minimum parity requirements are medically necessary.

Condoms:

Age: no age minimum or maximum criteria are appropriate, as condoms are a male method.

Parity: no minimum parity requirements are medically necessary.

IUD: A combination of parity and age were used to define this barrier:

Age: Menarche to 19 years if the parity criteria is greater than one. Twenty years and older if nulliparous. Providers who reported providing IUDs to all women under 20 years with or without parity restrictions were not considered to impose a barrier. In addition, providers who reported minimum age restrictions greater than 20 years or any maximum age limits were considered to impose a barrier.

Parity: One child if age is less than 20 years. More than one child required is considered a parity barrier at any age.

Injectables:

Age: Women aged 17 years and older can use this method safely. No maximum age criteria are appropriate. For women under 16 years of age, there are theoretical concerns regarding hypoestrogenic effects due to progesterone-only contraceptive use. Providers who report a minimum age over 16 years or who report any maximum age restriction are considered to impose a barrier.

Parity: no minimum parity requirements are medically necessary.

Sterilization

No medically-necessary age or parity restrictions for sterilization are appropriate. However, the guidelines strongly emphasize the need for appropriate and sensitive counseling with respect to age and parity, given that the method is permanent. Providers who report any minimum age, maximum age, minimum parity are considered to impose a barrier.

Marital Status and Spousal Consent Barriers

Any provider who reported providing contraceptives only to married women or only to women with spousal consent were considered to impose a barrier.

Data were analyzed using SPSS for Windows 3.1. It is important to note that standard errors were not calculated for any variables, so that cross-country comparisons are purely descriptive and differences in the various functional capacity and barrier indicators may or may not be statistically significant.

FUNCTIONAL CAPACITY ENVIRONMENT OVERVIEW

All types of facilities are represented in these Situation Analyses, including university, regional, and district hospitals, health centers and posts, and private and IPPF-affiliated clinics (see Table 1). The majority of facilities surveyed were government-run facilities: between 61% (Ghana) and 96% (Burkina Faso) of facilities are public providers. Facility setting, however, varied greatly. While only 27% of SDPs in the Senegal study were rural, a large majority (84%) of SDPs in Burkina Faso were rural.

In order to gain a general understanding of the functional capacity of facilities to provide family planning services, several indicators were calculated for each country (see Table 2). With respect to clinic infrastructure (includes running water, electricity, waiting room and bathrooms), Senegal has the highest mean number of items (3.4); Burkina Faso has 3.0 items and Ghana is lowest with 2.6 infrastructure items (data not shown). Each country's clinic infrastructure distribution followed similar patterns when analyzed by sector type: although sample sizes were low for private clinics and extremely low for IPPF-affiliate clinics, IPPF-affiliate clinics have the most amount of infrastructure, followed by private clinics, then public facilities. This trend is consistent with most of these indicators.

Senegal also had the highest mean for exam area items (includes auditory privacy, visual privacy, running water, adequate light, and cleanliness), with a mean of 4.5 items (data not shown). Burkina had the lowest level of exam area functioning with an overall mean of 3.2 items. Although a majority of staff in Burkina Faso and Senegal had received some type of clinical FP training, most had not received any IEC training (Ghana did not have two separate variables for this indicator). Finally, while roughly half of SDPs in Ghana and Senegal had received a supervisory visit in the last six months,

only a quarter of Burkina Faso's public facilities had received a visit and *none* of the private or IPPF-affiliate clinics in Burkina had received a supervisory visit.

It is of interest to note which types of facilities in each country offer specific methods and what methods are generally available in each country (see Table 3). In all countries, most of the IPPF-affiliate clinics offer all modern contraceptive methods except for sterilization. However, none of Senegal's five ASBEF clinics offer injectables and less than one-half of Ghana's 22 PPAG clinics offer progesterone-only pills, a safe and effective alternative to COCs for breastfeeding women. In general, a lower percentage of Ghana's private clinics offer various family planning methods than private clinics in Burkina and Senegal. However, Ghana's sample size is roughly four times that of Senegal's private clinic sample size and ten times that of Burkina Faso's, so large statistical variations may explain these differences.

Among public clinics, Burkina's public SDPs offer fewer method choices than those of Senegal and Ghana. For example, only 21% of Burkina SDPs offer spermicides (as compared to 84% of public SDPs in Senegal and 97% in Ghana). Furthermore, only half (51%) of Burkina's public clinics offer condoms, whereas 96% and 98% of public SDPs offer condoms in Senegal and Ghana respectively. Burkina Faso's public clinics are also similarly lower for prescription methods like the IUD and injectable. Less than 1% of Burkina Faso's public clinics offer sterilization; 6% and 10% of public clinics offer sterilization in Senegal and Ghana.

BARRIERS TO CONTRACEPTIVE ACCESS

Table 4 shows the results of the barriers analysis with respect to contraceptive method and overall barrier indicators by country. Several major themes arise from this analysis by method and by barrier:

Condoms: the lowest percentages of staff reporting barriers for any given method was for condoms, the most temporary method and the only barrier method examined in this analysis. Staff reported the lowest age (both minimum, maximum, and overall) barriers, the youngest minimum age ranges and older maximum age ranges than other methods. They also reported imposing the fewest parity and marital barriers overall of any method. However, spousal consent barriers were consistent with other methods in the analysis (ranging from 18-32%). These lower reported barriers are consistent with the nature of the method: it is a nonprescription method and is probably used more often to prevent HIV/STD transmission than within marriage as a family planning method.

Sterilization: On the other end of the FP spectrum, sterilization is not a widely-accessible method and the sample size of sterilization providers is very small. However, percent of staff reporting having restrictions to this method fall within the middle of the spectrum of provider-induced barriers. Even more curious, Ghana has extremely low barriers that range from 5-12% on individual barriers. It's overall method barrier is 14%, compared to Burkina's 92% and Senegal's 75%. Although it could be attributed to a small sample

size, Ghana's Situation Analysis interviewed 59 staff, which is several times the sample size of Burkina Faso and Senegal. It may still be attributed to variation, or perhaps a recent training program on sterilization.

Injectables, COCs, and IUDs: Staff from all three countries were most likely to impose the greatest barriers on injectables and COCs, followed by IUDs. Table 3 may indicate that these last two methods are the most widely-available and popular method, and therefore staff may have the inclination or opportunity to impose the most restrictions on these.

Age: Age barriers seem to be the most common barrier reported by staff. The overall barrier estimations show that 60% (Burkina Faso), 81% (Senegal) and 91% (Ghana) of staff impose either a minimum age, a maximum age, or both for any contraceptive method. This is probably partly a function of the definitions of barriers used in this analysis. Any minimum age requirements for COCs, IUDs for women with at least one child, condoms, and sterilizations and any maximum age requirements for IUDs for women with at least one child, injectables, condoms, and sterilizations were all defined as age barriers.

Parity. In general, percent of staff reporting parity requirements was only slightly lower than the percentage reporting age requirements. Ghana had the lowest parity requirements of all the countries for condoms, sterilizations, and IUDs. However, it also had the highest parity requirements compared to Burkina Faso and Senegal for COCs and injectables

Marital Status: Overall, marital status was the lowest barrier to FP among the three countries. In Burkina Faso, 13% of staff reported barring services to unmarried women. Of the Senegalese staff interviewed, 17% imposed marital status restrictions and 48% of Ghanian staff imposed marital status barriers.

Spousal Consent: It is interesting to note that spousal consent requirements were consistently several-fold higher than marital status requirements for all methods in all countries. For example, in Burkina Faso, only 4% of providers will not provide FP to unmarried clients; however, 33% of providers require spousal consent.

Overall Barrier by country: Ghana staff were most likely to report any type of barrier for any method (93%). Burkina Faso staff were the least likely (79%) . However, the lower number is still quite high.

CONCLUSIONS

This is a prescriptive analysis in that it sets a standard of medically-acceptable barriers and judges providers by these standards, regardless of financial circumstances,

legal barriers to providing care, or level of provider training. Once again, this analysis is purely descriptive and no comparisons between countries can be statistically validated. However, this type of analysis can be used to determine where training or resources might be placed in order to improve choice of methods while protecting women from adverse medical side effects. However, it does not address any type of social or moral debate on FP access.

Barriers are highest for the most commonly accepted and available methods in each of these countries. First efforts might be concentrated among providers of these methods with respect to age and parity.

There may be some question in this type of analysis as to whether these barriers are reported independently of one another or whether a provider would require every criteria reported to be met by all clients. There are many inconsistencies, such providing methods to women as young as 15 but requiring 3-5 children as a parity requirement. It may also be questionable whether or not a self-report of criteria absent from any type of context is truly applied in practice. It would be interesting to examine the observation module variables regarding which decisions are made by the provider (with respect to eligibility criteria) with the self-reported eligibility criteria as a consistency check.

TABLE 1: DESCRIPTION OF SERVICE DELIVERY POINTS (SDPS)

	Burkina (1995) (n=334 SDPs)	Senegal (1995) (n=177 SDPs)	Ghana (1993) (n=360 SDPs)
TYPE			
national/univ hosp	0.2%	1.1%	0.6%
regional hosp	0.5	2.8	2.2
district hosp w/surg unit	2.6	N/A	N/A
district hospital	8.6	N/A	13.3
health center and/or health	84.2	74.0	45.3
post	2.7	16.9	20.8
maternity/MCH/FP	0.6	2.3	11.7
private clinics	0.6	2.8	6.1
ABBEF/ASBEF/PPAG			
SECTOR (recoded from TYPE)	(n=334 SDPs)	(n=177 SDPs)	(n=360 SDPs)
public	96.1%	78.0	61.4%
private/NGO/Mission	3.3	19.2	32.5
IPPF affiliate	0.6	2.8	6.1
LOCATION	(n=334 SDPs)	(n=180 SDPs)	(n=399 SDPs)
rural	83.7%	26.7%	35 3%
urban	8.8	48.3	44.4
semi-urban	7.6	25.0	20.3

* Health centers and posts were combined into one code.

TABLE 2: FUNCTIONAL CAPACITY OF SDPS

	Burkina (1995)			Senegal (1995)			Ghana (1993)		
	Public	Private	IPPF	Public	Private	IPPF	Public	Private	IPPF
1. **% of SDPs having appropriate infrastructure:**	(n=321)	(n=11)	(n=2)	(n=138)	(n=34)	(n=5)	(n=221)	(n=117)	(n=22)
water	72.9%	100.0%	100.0%	79.7%	91 2%	80.0%	39.4%	53.0%	40.9%
electricity	79 8	81.8	100.0	88.4	94.1	100.0	42.1	59.0	68.2
waiting room	69.4 (n=320)	72.7	100.0	85.5	97.1	100.0	95.5	94.0	90.9
bathroom	76.9% (n=320)	100.0	100.0	74.6	94.1	100.0	68.3	77.8	59 1
all four	39 6	72.7	100.0	54.3	79.4	100.0	19.5	36.8	36.4
mean # of items	2.99	3 52	4.00	3.28	3.76	3.80	2.45	2.84	2.59
1 **% of SDPs having satisfactory exam area:**	(n=321)	(n=11)	(n=2)	(n=138)	(n=34)	(n=5)	(n=221)	(n=117)	(n=22)
auditory privacy	63 9%	72.7%	100.0%	94.2%	100 0%	100.0%	82 8%	82.1%	86 4%
visual privacy	75.9 (n=320)	81.8	50.0	94 9	97 1	100.0	86.4 (n=220)	85.5	95.5
cleanliness	66.7	90 9	50.0	94.9	94 1	100 0	86.9	92.3	100.0
adequate light	81.9	100 0	100.0	91.3	91.2	100 0	85.0 (n=220)	88.0	86 4
adequate water	31.5	81.8	100.0	71.7	82 4	100 0	69.2	70 9	72.7
all five	0 0	0.0	0.0	60.1	70 6	100.0	54.8	55 6	63.6
mean # of items	3 20	4.29	3.85	4 47	4.65	5.00	4.11 (n=220)	4 19	4.41
2 **% of staff with:**	(n=635)	(n=39)	(n=2)	(n=262)	(n=79)	(n=16)	(n=493)	(n=166)	(n=38)
clinical training	67.1%	82 1%	100.0%	63.0%	57 0%	68.8%	N/A		
IEC training	15.7	12.8	50.0	25.2	17 7	13 9	N/A		
both	11.8	12.8	50.0	23.3	13.9	31.3	59.6%	42.8%	68.4%
1. **% of SDPs who have received at least one supervisor visit in the last 6 months**	(n=314)	(n=11)	(n=2)	(n=136)	(n=33)	(n=5)	(n=203)	(n=107)	(n=20)
	22.6%	0.0%	0.0%	47.8%	48 5%	40.0%	56.2%	42.1%	100.0%

TABLE 3: CONTRACEPTIVE METHOD AVAILABILITY

	Burkina (1995)			Senegal (1995)			Ghana (1993)		
	Public (n=321)	Private (n=11)	IPPF (n=2)	Public (n=138)	Public (n=34)	IPPF (n=5)	Public (n=221)	Private (n=117)	IPPF (n=22)
% of SDPs offering combined OCs	98.1% (n=320)	100.0%	100.0%	99.3%	100.0%	100.0%	98.6%	92.3%	100 0%
% of SDPs offering prog-only OCs	61.4	100 0	100.0	97.1	100.0	100 0	71.9	64 1	45 5
% of SDPs offering spermicides	20.6 (n=320)	81.8	100.0	84.1	94.1	100 0	96.8	86.3	100 0
% of SDPs offering condoms	50.8	81 8	100.0	96.4	100 0	100.0	98 2	94 0	95 5
% of SDPs offering NFP	12.5	18 2	0.0	3.6	5 9	0 0	48 0	39.3	50 0
% of SDPs offering IUDs	21.9 (n=320)	90 9	100.0	79.7	94 1	100 0	67 4	33.3	77 3
% of SDPs offering injectables	53.9	100 0	100.0	70 3	67.6	0.0	98.6	92.3	86 4
% of SDPs offering tubal ligation	0 6	9.1	0 0	5.8	2 9	0.0	10.0	1 7	0 0

TABLE 4: BARRIERS

	Burkina (1995)	Senegal (1995)	Ghana (1993)
% of staff who report imposing barriers on a particular method, among SDPs that offer the method:			
COC			
min age	53.5% (n=624)	69.7% (n=357)	77.3% (n=763)
range min age barrier	12-38 years	12-40 years	10-40 years
mean min age barrier	16.6 years	17.5 years	18.1 years
max age	27.8% (n=384)	67.6 (n=225)	73.2% (n=604)
range max age barrier	25-39 years	30-39 years	25-38 years
mean max age barrier	34 9 years	35.1 years	34.8 years
either age (min, max, or both)	58.0% (n=624)	85.1% (n=316)	80 9% (n=763)
parity	10.6% (n=608)	26.4% (n=318)	54 6% (n=765)
range parity barrier	1-5 children	1-12 children	1-10 children
mean parity barrier	2.41 children	1.87 children	1.94 children
marital status	3.5% (n=626)	6.6% (n=318)	24 1% (n=765)
spousal consent	32.7% (n=626)	25.5% (n=318)	35.8% (n=765)
any barrier to COC	72.9% (n=614)	90.6 (n=318)	83.5% (n=765)
CONDOMS			
min age	10.2% (n=360)	7.3% (n=355)	35 5% (n=712)
range min age barrier	14-22 years	14-20 years	14-26 years
mean min age barrier	16.2 years	16.5 years	16 8 years
max age	5.3% (n=367)	2.8% (n=355)	18 2% (n=754)
range max age barrier	40-55 years	30-60 years	28-55 years
mean max age barrier	49.5 years	42.0 years	49 3 years
either age (min, max, or both)	10.2%(n=367)	8.6%(n=314)	35 9% (n=754)
parity	0.2%(n=353)	1.6%(n=314)	8.3% (n=763)
range parity barrier	none (n=1)	1-2 children	1-10 children
mean parity barrier	2.00 children	1.40 children	2.10 children
marital status	1.1% (n=367)	0.6% (n=314)	4.5% (n=761)
spousal consent	18.1% (n=367)	19.1% (n=314)	31.6% (n=762)
any barrier to CONDOMs	25.9% (n=352)	27.1% (n=314)	48.4% (n=759)
IUD	**Burkina (1995)**	**Senegal (1995)**	**Ghana (1993)**

TABLE 4: BARRIERS

min age			
range min age barrier	16 9% (n=203)	23.1% (n=290)	21.6% (n=426)
mean min age barrier	15-45 years 23 4 years	12-40 years 23.0 years	12-37 years 18.5 years
max age			
range max age barrier	16 0% (n=209)	20.5% (n=303)	26.5% (n=476)
mean max age barrier	35-50 years 45.2 years	35-60 years 43.5 years	30-55 years 43 0 years
either age (min, max, or both)	20.8% (n=209)	32.5% (n=265)	29.2% (n=476)
parity			
range parity barrier	23.9% (n=117)	29.9% (n=184)	9.1% (n=470)
mean parity barrier	1-5 children 2.08 children	1-7 children 2.60 children	1-10 children 2.14 children
marital status	15.7% (n=217)	11.4% (n=287)	20.7% (n=492)
spousal consent	18.8% (n=217)	25.4% (n=287)	18.3% (n=492)
any barrier to IUDs	59.1% (n=150)	70.5% (n=220)	38.8% (n=482)
INJECTIONS			
min age			
range min age barrier	36.7% (n=388)	44.9% (n=236)	74.4% (n=680)
mean min age barrier	17-45 years 29 8 years	17-40 years 28.1 years	17-36 years 27.7 years
max age			
range max age barrier	24 4% (n=405)	31.2% (n=260)	70.8% (n=757)
mean max age barrier	30-55 years 44 5 years	35-55 years 41.6 years	24-55 years 40 9 years
either age (min, max, or both)	41.4% (n=405)	57.1% (n=231)	79 0% (n=757)
parity			
range parity barrier	66 2% (n=402)	37.5% (n=232)	72.5% (n=759)
mean parity barrier	1-5 children 2.95 children	1-7 children 3.23 children	1-8 children 3.15 children
marital status	11 2% (n=406)	6.9% (n=232)	34.3% (n=758)
spousal consent	26.5% (n=406)	20.7% (n=232)	28.2% (n=758)
any barrier to INJECTIONs	79.9% (n=402)	73.3% (n=232)	83.0% (n=759)
STERILIZATION	**Burkina (1995)**	**Senegal (1995)**	**Ghana (1993)**

TABLE 4: BARRIERS

min age			
range min age barrier	33.3% (n=7)	52.6% (n=19)	8.5% (n=59)
mean min age barrier	35-40 years	25-45 years	30-35 years
	38.8 years	37.6 years	32.6 years
max age			
range max age barrier	41.7% (n=7)	31.6% (n=19)	6.8% (n=59)
mean max age barrier	40-45 years	none (n=6)	35-45 years
	41.0 years	45.0 years	40.3 years
either age (min, max, or both)	58.3% (n=7)	62.5% (n=16)	11.9% (n=59)
parity			
range parity barrier	91.7% (n=7)	68.8% (n=16)	10.2% (n=59)
mean parity barrier	3-5 children	2-9 children	3-8 children
	4.09 children	5.46 children	4.17 children
marital status	41.7% (n=7)	25.0% (n=16)	5.1% (n=59)
spousal consent	41.7% (n=7)	50.0% (n=16)	5.1% (n=59)
any barrier to STERILIZATIONs	91.7% (n=7)	75.0% (n=16)	13.6% (n=59)
% of staff who report imposing a particular barrier on any method			
available sample size:	(n=676)	(n=361)	(n=783)
AGE (one or both)	59.9%	81.2%	91.1%
PARITY	44.9	43.2	79.9
MARITAL STATUS	12.8	16.6	47.8
SPOUSAL CONSENT	37.8	38.0	58.2
% of staff who report imposing any barrier on any method:	79.4%	85.0%	93.0%