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MOH Physicians' KAP Study on Hormonal Methods and Female Sterilization

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This study was carried out by the Primary Health Care Initiatives (PHCI) project in an effort to improve the provision of family planning services provided by the Jordanian Ministry of Health. The study aimed at exploring the practices, knowledge and attitudes of MoH providers towards hormonal methods and female sterilization.

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Summary of Findings and Recommendations

The Physicians' KAP study on Hormonal Methods and Female Sterilization was carried out between June and July 2001. The study is part of a larger study designed and implemented by the Engender Health in order to collect data from service providers on knowledge, attitudes and practices regarding hormonal methods (oral contraceptives, Norplant, injectables) and female sterilization. A total of 101 physicians were selected and interviewed to determine general trends in the provision of family planning services, knowledge about specific family planning methods, female sterilization, and attitudes towards family planning methods. Results of this survey are expected to guide future family planning training activities and service delivery plans.

The majority of the providers were working at Primary Health Care facilities with a regional distribution that resembles that of the health centers. Males outnumbered females at a ratio of 3:2. With a mean age of about 40 years, 91.1% of the providers were married with an average of 3.5 children. While 12.9% of the sampled subjects were new employees at the MoH (less than one year of service), the remaining physicians had worked an average of 4.9 years at the MoH. Only half of the sample reported receiving at least one type of training during the five years preceding the survey.

Family planning provision and counseling

- During the year preceding the survey, 81.2% of the respondents reported having prescribed or provided at least one method of family planning, while 84.2% reported discussing or counseling women on family planning methods. The Combined Oral Contraceptives was the most commonly prescribed or discussed method. Counseling couples or men on family planning methods was found to be low among the respondents (18.8%). Half of the respondents (55.4%) reported providing family planning counseling to couples that have completed their family size. The IUD was the most common method (57.1%) recommended for such couples. Condoms and traditional methods were the most frequently mentioned methods by providers recommending a delay in first pregnancy. Depot-Provera and the IUD were the methods most frequently mentioned by providers recommending a family planning method for couples wishing to space their next child. Outranked only by the IUD, Tubal Ligation was mentioned by 36.6% of the providers as a recommendation in situations where no more children are desired.

Knowledge about family planning

- Providers tended to set an age limitation when perceiving oral contraceptives. A high percentage of providers reported not knowing the minimum and maximum age for prescribing Depot-Provera and Norplant and tended to ignore the appropriateness of Progestin only pills for women over the age of 40. With the exception of Norplant, at least 80% of providers who reported a specific minimum number of children for prescribing or referring women for modern family planning methods specified a minimum of 3 children. Providers' knowledge of restrictions in providing modern

family planning methods to women during breast-feeding and immediately postpartum was found to be lacking and not thorough. A clear knowledge deficit was identified in relation to the various contraindications, advantages and disadvantages of the Combined and Progestin only pills, Depot-Provera and Norplant. The most common misconception heard by the providers about the Combined Oral Contraceptives was cancer perception. Meeting the training needs for Norplant provision was a pronounced barrier identified by the providers.

Female Sterilization

- Less than one third of the providers said that they would refer women for Tubal Ligation indicating mostly medical situations as a reason for such referrals. A completed family size was indicated by 48.4% as a reason for Tubal Ligation referral. The providers considered grand multiparity as both a medical and non-medical indication for Tubal Ligation. About 45% of the providers gave 4.7 children as the average number required before a woman should seeks Tubal Ligation, giving a higher average for the minimum number of boys than for girls (2.6 and 1.9 respectively). Providers tended to limit information offered to couples about Tubal Ligation within the disadvantages of the procedure. Most of the factors reported by the providers as barriers hindering women from accepting Tubal Ligation had a cultural, religious or personal attribute.

Attitudes and beliefs

- More than a third of the providers believed that female sterilization is Haram. Other modern family planning methods were reported by two thirds of the providers to be acceptable by Islam. About two thirds of the providers believed that men are the primary decision makers in family planning, and that acquisition of a spousal consent prevents women from getting a Tubal Ligation. Nine out of ten providers agreed that even with the husband's consent, a woman who gets a Tubal Ligation might face family problems. Forty percent of the providers said that they do not feel comfortable discussing Tubal Ligation with clients.

Recommendations

- This study recommends increasing the providers' knowledge of modern family planning methods, particularly Norplant and Depot-Provera. Developing opportunities for marketing Tubal Ligation among couples or men through a carefully designed information-education-communication (IEC) program is also recommended.

Section 1: Objectives and Methodology

1.1 Background

The Jordanian society continues to value large families reflected in the need and desire to have more children. The 1997 Jordan Population and Health Survey reported that more than 55% of women who have three children and a considerable proportion of women who have four or five children want more. The survey provides some insight to the potential demand for contraception, particularly for permanent and long acting methods. Results indicated that 27% of the births in the 5 years preceding the Survey were mistimed and 17% were unwanted. Furthermore, 47% of the interviewed women reported not wanting any more children and two in three of the surveyed contraceptive users wanted to stop childbearing[1].

Results from the 2000 Jordan Annual Fertility Survey[2] indicate that 55.8% of married women were using a contraceptive method at the time of the survey. The most widely currently used modern method was identified as the IUD (23.7%) followed by the pill (8.4%). Female sterilization decreased from 4.2% in 1997 to 3.8% in year 2000. Being relatively new in Jordan, the long term acting hormonal methods, Norplant and Injectables, achieved less than 1% usage rate in year 2000. Although the potential role for permanent and long acting contraception methods in the Jordanian family is high, female sterilization and long acting hormonal contraceptives account for less than 10% of all contraceptive method usage. While IUD and pill use have increased over the past ten years by 21.5% and 9.7% respectively, female sterilization declined from 20% of modern method use to 9.7% over the same period. Introduction of long-acting hormones was expected to increase use of modern contraceptives in Jordan, but the impact has been negligible, with fewer than 1 in 50 modern method users relying on either of the two methods. As a result, exploring the providers' influence on use of hormonal methods and female sterilization becomes crucial in light of the low utilization rates of these methods.

1.2 Purpose of the Study

This study aims at obtaining an understanding of the role of service providers in recommending and influencing family planning methods. Special focus is given to the knowledge, attitudes and practices regarding sterilization, the contraceptive pill, Norplant and Injectables. It is hoped that the results can assist in developing a plan of action for increasing the use of permanent and hormonal contraceptive methods in Jordan. In addition, data from this report is expected to strengthen the ability of family planning program managers in identifying and solving service delivery problems, and in identifying training needs in family planning for health providers.

[1] Population and Family Health Survey. (1997). Jordan: Department of Statistics. Demographic and Health Surveys.
[2] Jordan Annual Fertility Survey. (2000). Department of Statistics. Amman, Jordan.

1.3 Methodology

This study is part of a larger study designed and implemented by Engender Health in order to collect data from service providers on knowledge, attitudes and practices regarding hormonal methods (oral contraceptives, Norplant, injectables), and female sterilization. The study used a cross-sectional descriptive design where data was collected from a sample of providers by face-to-face interviews. A five-part questionnaire developed by Engender Health and supplemented by the Primary Health Care Initiatives Project PHCI was used.

The questionnaire used included five sections, namely: 1) general background information about the provider; 2) general family planning provision services for selected methods, including discussion, counseling and recommendation of family planning method in selected situations; 3) criteria for providing/referral of pills and hormonal methods; 4) information about specific family planning services including advantages, disadvantages, contraindication, barriers and misconceptions heard; 4) female sterilization including indications, minimum age, children's gender and number; information given to client, barriers to women's acceptance and institutional barriers 5) religious understanding of selected family planning methods and statement reflecting attitudes and values of family planning methods.

Fieldwork for data collection was carried out by the Market Research Organization (MRO) between June and July, 2001, where 6 interviewers and 3 supervisors were used. Guidelines to help conduct the interview and complete this survey consistently and accurately were provided to the interviewers.

While assuming maximum variability of expected prevalence, and using a 95% confidence interval and a 10% error level, a sample size was calculated using the following formula:

$n=(z)^2pq/(d)^2$ $n=(1.96)^2(0.5)(0.5)/(0.1)^2= 96$

where:
n = sample size
z = confidence limit
p = prevalence rate
q = 1-p
d = precision level

Therefore, a sample in which 100 health care facilities were randomly selected and a list of names of relevant physicians obtained from each of these facility. One physician was selected randomly for interviewing (in facilities where there was one GP, he or she was selected for completing the questionnaire). In cases were the selected name was not available, a substitute was chosen and interviewed. The design effect was not considered due to cost limiting factors.

Collected data was entered and checked by the Market Research Organization. Questionnaires and an SPSS data file were then submitted to the PHCI, where data was rechecked and analysis done using SPSS. This report summarizes the characteristics of the sample, patterns in family planning provision, knowledge about modern family planning, and attitudes towards family planning.

Section 2: Sample Characteristics

This section describes the general characteristics of the family planning service providers working at the sampled MoH health centers. Selected providers were interviewed using a questionnaire that included a section on their bio-data including educational and practical experience.

2.1 Demographic characteristics

A total of 101 providers were interviewed over a period of one month. The providers were defined as physicians working at various MoH health centers.

Table 2.1 summarizes the demographic characteristics of the sample. Most of the health providers were working at Primary health centers (PHCs). Only 38% of the respondents were general practitioners running MCH clinics. The distribution of the providers over the northern, central and southern regions was about 45, 37 and 18 percent respectively. This distribution reflects that of the health centers. The male providers outnumbered the females (about 3:2).

Most of the providers (91.1%) were married with an average of 3.5 children. Half of the ever-married providers had between one and three children.

With an average of about 40 years, the ages of the providers ranged between 26 and 56. The majority of the providers (84.1%) were within early and late middle age hood.

Table 2.1: Demographic Characteristics of the Sampled Providers

Providers' Characteristics	**n**	**%**
Type of Health Center		
CHC	11	10.9
PHC	90	**89.1**
Region		
North	46	45.5
Central	37	36.6
South	18	17.8
Job Affiliation		
General Practitioner	63	**62.4**
General Practitioner/MCH	38	37.6
Sex		
Male	62	**61.4**
Females	39	38.6
Marital Status		
Married	92	**91.1**
Divorced/No Response	2	2
Single	7	6.9
*Number of Children**		
None	4	4.3
1 – 3	47	**50.5**
4 - 5	32	34.4
≥6	10	10.8
Age Category		
≤ 30years	11	10.9
31-40 years	39	**38.6**
41-50 years	46	**45.5**
≥ 51years	5	5
Total Number of Cases	***101***	***100***

* Percent out of ever married

2.2 Professional background

The sampled providers received their initial medical training from different countries including Jordan. Table 2.2a shows that the majority of the providers received their first degree from medical schools in Eastern European countries.

Table 2.2a: Country Affiliated with Initial Medical Training

Country	%
Jordan	13.9
Arab Countries (Egypt, Syria, Iraq, Yemen)	18.8
Eastern Europe (Russia, Romania, Yugoslavia)	58.4
Western Europe (Italy, Greece)	8.9

At the time of the data collection, 12.9% of the providers were relatively new employees at the MoH with less than one year. The remaining providers had an average of 4.9 years of experience at the Ministry with a range of 19 years (minimum 1, maximum 20).

Table 2.2b shows the main fields of training received by participants. Only half of the sampled providers (50.5%) reported receiving at least one type of training during the five years preceding the survey.

Table 2.2b: Distribution of Training Received during last 5 years

Field of Training	n	%*	%**
Clinical Training in IUDs	29	22.5	28.7
Quality of Care	22	17.1	21.8
Interpersonal Skills or Counseling	22	17.1	21.8
Infection Prevention/Control	21	16.3	20.8
Norplant (insertion/removal)	16	8.9	15.8
Contraceptive Technology Update	12	9.3	11.9
Other Reproductive Health Issues	7	5.5	6.9
Total Responses	129	100	

* Percents are from total responses , ** Percents are from total providers

On the whole, attending training by the providers was reported to be of low frequency. When examining responses for various training topics as reported by the practitioners, the highest number (22.5%) was in clinical training in IUDs, and the least was in update on contraceptive technology. Almost all of the reported training (96.1%) was received in Jordan, with 76% being offered by the Ministry of Health. The average time lapse for training received was 2.38 years.

There were significant variations in training by region (χ^2, p=0.005). Received training opportunities were highest among those providers from the central (70.3%) and lowest among those working in the south (27.8%). Providers working in the north reported receiving 43.5% training.

Section 3: Provision of Family Planning

3.1 Prescribing and providing family planning

On the whole, 81.2% of the respondents reported providing or prescribing at least one family planning method during the year preceding the survey. Table 3.1 presents various family planning methods identified by the providers. The Combined Oral Contraceptives was the most commonly prescribed method by those who reported providing or prescribing family planning over the preceding year. The Progestin only pill, barrier methods and IUD followed the Combined Oral Contraceptives consecutively. Norplant insertion and removal was the least likely method (2.4%) mentioned by the providers.

Table 3.1: Distribution for Method of FP Provided/Prescribed during the last year*

FP Method	N*	%*
Combined Oral Contraceptives	79	96.3
Progestin only Pill	66	80.5
Barrier Methods (Condom, others)	64	78.0
IUD	55	67.1
Depot-Provera	24	29.3
Traditional Methods (including LAM)	12	14.6
Vaginal tablets	5	6.1
Norplant (insertion/removal)	2	2.4

*Numbers are for responses (n=405), and Percents are responses out of valid cases (n=82)

3.2 Discussing family planning with women

Most of the providers (84.2%) reported discussing or counseling women on family planning methods during the year preceding the survey. Table 3.2 shows that among those who gave a positive response for counseling or providing information to women during the past year, 91.7% mentioned Combined Oral Contraceptives. Discussion and counseling for Norplant and Tubal Ligation were the least likely mentioned methods.

Table 3.2: Family Planning Methods Discussed with women during the Past Year*

FP Method	N	%
Combined Oral Contraceptives	77	91.7
Condoms	65	77.4
Progestin only Pill	61	72.6
IUD	57	67.9
Traditional Methods, Withdrawal, Rhythm	41	48.9
LAM	36	42.9
Depot-Provera	34	40.5
Vaginal tablets/spermicide	21	25
Norplant	7	8.3
Tubal Ligation	5	6.0

*Numbers are for responses (n=404), and Percents are responses from valid cases (n=84)

The results indicate that respondents generally provide counseling on family planning methods especially contraceptive pills. However, opportunities still exist for providing

more information and counseling on other methods such as Norplant and Tubal Ligation. Even though the type and content of information provided through counseling women cannot be portrayed in this survey, communicating opportunities for family planning methods in terms of availability might be effective in increasing awareness for satisfying unmet need.

3.3 Family planning counseling for couples who have completed family size

Half of the respondents (55.4%) reported having ever provided family planning counseling to couples that have completed their family size. Table 3.3 shows that the IUD was the most common method (57.1%) recommended by respondents who counseled these couples. In view of the fact that referring or giving advice on Tubal Ligation is an important option to consider when advising couples that want no more children, this option did not occupy a sizable proportion of responses.

Table 3.3: Family Planning Recommended for Couples who Completed their Family Size*

FP Method	N	%
IUD	32	**57.1**
Continue using method of choice	26	46.4
Pills	12	21.4
Advise or refer for Tubal Ligation	10	17.9
Withdrawal or abstinence	8	13.3
Long-term hormonal method (DMPA/Norplant)	3	5.4
Recommendation varies according to family situation	2	3.6
Other	2	3.6
Condoms	1	1.8

*Numbers are for responses (n=96), and Percents are responses from valid cases (n=56)

These results stress the need to encourage health providers to discuss long-term family planning methods. Health providers need to identify family planning opportunities where couples want no more children in order to recommend a method that meets their need effectively.

3.4 Discussing family planning with couples or men

Less than one fifth of the respondents (18.8%) reported discussing or counseling couples or men on family planning methods during the past year. Table 3.4 shows that among those who gave a positive response for counseling or providing information to couples or men, the highest was 89.5% for discussing condoms. Discussion and counseling for Norplant and Tubal Ligation were very low and were the least likely mentioned methods. Percentages shown in Table 3.4 would seem negligible when taking into account the overall responses.

Table 3.4: Family Planning Methods Discussed with Couples or Men during the Past Year*

FP Method	N	%
Condoms	17	**89.5**
Combined Oral Contraceptives	14	73.7
Traditional Methods, Withdrawal, Rhythm	13	58.4
Progestin only Pill	11	57.9
IUD	9	47.4
LAM	6	31.6
Vaginal tablets/spermicide	5	26.3
Depot-Provera	4	21.1
Norplant	2	10.5
Tubal Ligation	1	5.3

*Numbers are for responses (n=82), and Percents are responses from valid cases (n=19)

These results stress the need to encourage health providers to discuss family planning methods with couples or men, since providing information on contraceptive methods to men and women is equally important. Opportunities for marketing Norplant and Tubal Ligation among couples or men should be emphasized when promoting family planning methods.

3.5 Recommended Family Planning Methods

The most frequently mentioned methods by providers as a recommendation for delaying first pregnancy were condoms and traditional methods (Table 3.5). Almost 18% of the providers said that they would not mention any method to clients who wish to delay their first born, and almost all of these responses came as a first recommendation.

None of the providers mentioned Depot-Provera and Tubal Ligation when recommending family planning methods for clients wishing to delay their first-born. This result might be linked to the long-term effect of Depot-Provera and the permanent effect of the Tubal Ligation. Even though the Combined Oral Contraceptives is well known for its convenience and use by women with or without children, it was only mentioned by about 19% of the providers. Similarly, despite the lack of limitations in the use of Norplant in nulli-parous women, only one respondent mentioned it. These results indicate that providers need to review the guidelines for various contraceptive methods in a more comprehensive manner.

When asked to mention family planning methods recommended for couples wishing to space their next child, providers tended to particularly mention modern family planning methods. Table 3.5 shows that traditional methods were mentioned by only 1% of the providers. The most frequently mentioned method was Depot-Provera (51.4%) followed by the IUD (50.6%). The Combined Oral Contraceptives and Norplant were equally mentioned (42.6%), while the Progestin only pill was mentioned by about 20% of the providers. Tubal Ligation was mentioned by a quarter of the providers, which is an unexpected recommendation for a couple that wishes to space and not stop childbearing.

Table 3.5: Percentage for Family Planning Methods Mentioned as a Recommendation in Selected Situations

Family Planning Method	Delaying First Birth*	Spacing Next Child*	No More Children are Desired*
Combined Oral Contraceptives	18.9	42.6	28.7
Pregestin only Pill	6.9	20.9	5.0
IUD	6.0	50.6	46.5
Depot-Provera	--	51.4	7.0
Norplant	1.0	42.6	8.0
Vaginal Tablet	6.9	8.0	3.0
Condom	56.4	3.0	10.0
Withdrawal	41.6	1.0	8.0
Rhythm	42.7	--	7.0
Tubal Ligation	--	24.9	36.6
Depends on Client's Health	5.0	3.0	19.8
Depends on Client's Choice	4.0	4.0	16.9
None Recommended	17.8	6.0	5.9

* Multiple responses allowed; percents do not total to 100%

Providers mentioned the IUD, Tubal Ligation and the Combined Oral Contraceptives more frequently when asked to recommend family planning methods for clients who want no more children. Tubal Ligation was mentioned by more than a third of the providers (36.6%) only to be outranked by the IUD. Other modern methods and all traditional methods were each mentioned by less than 10% of the providers. Consideration of client's health or choice when recommending family planning methods seem to gain more value when dealing with families who wish to have no more children.

In summary, providers tend to recommend traditional methods for clients who wish to delay their first-born. Modern methods are more commonly recommended for clients who wish to space their next child. Depot-Provera and Norplant are methods that seem to be ignored when recommending family planning methods in situations other than spacing children.

Section 4: General Knowledge about Modern Family Planning

4.1 Recommended ages for modern family planning

Providers were asked to specify the minimum and maximum ages required before prescribing or referring women for modern family planning methods. Table 4.1a and 4.1b show that a considerably high percentage of the providers were unaware of no age restrictions for the listed family planning methods during the childbearing age (according to the medical eligibility contraceptive use guidelines defined by the WHO[3]).

Table 4.1a: Minimum Age Recommended for Providing Modern Family Planning Methods

Family Planning Method	Age Group %				No Specific Age Required (%)	Don't Know* (%)
	< 20	20-25	26-35	> 35		
Combined Oral Contraceptives	15.8	38.6	12.9	--	29.7	3.0
Progestin only Pill	15.8	33.7	12.9	1.0	31.7	5.0
IUD	6.9	25.7	12.9	--	**50.5**	4.0
Depot-Provera	3.0	10.9	9.9	4.0	38.6	**33.7**
Norplant	3.0	7.9	6.9	4.0	20.8	**57.4**

*This category included those who reported not providing the service or did not respond

A considerably high percentage of providers indicated a lack of knowledge in respect to the recommended minimum and maximum age for prescribing Depot-Provera and Norplant. Furthermore, despite the known lack of age restriction in using the IUD, only half of the providers reported that no specific age is required for prescribing it. While oral contraceptives are widely known for their appropriateness for all ages, the providers tended to perceive their use with an age limitation, especially when asked to specify a maximum age requirement.

Table 4.1b: Maximum Age Recommended for Providing Modern Family Planning Methods

Family Planning Method	Age Group %				No Specific Age Required (%)	Don't Know* (%)
	30-35	36-40	41-45	> 45		
Combined Oral Contraceptives	42.6	38.6	4.0	4.0	7.9	3.0
Progestin only Pill	32.7	36.6	7.9	5.0	12.9	5.0
IUD	15.8	17.8	12.9	2.0	**48.5**	3.0
Depot-Provera	7.9	17.8	4.0	1.0	35.6	**33.7**
Norplant	5.9	13.9	2.0	2.0	17.8	**58.4**

*This category included those who reported not providing the service or did not respond

[3] Improving Access to Quality Care in Family Planning: Medical eligibility criteria for contraceptive use. Second Edition. WHO. 2000.

On the whole, providers seem to set age limitations for modern family planning methods. The fact that the Progestin only pills are appropriate for women over 40 years seems to have been ignored by the providers. Assisting providers in obtaining more information on lack of age restriction for family planning methods is needed.

4.2 Minimum number of children

Providers were asked to specify the minimum number of children a woman must have before prescribing or referring her for family planning methods. Table 4.2a shows that providers generally think that a woman has to have one or two children before prescribing or referring her for family planning. More than half of the providers think of prescribing a modern family planning method, other than the Norplant, to women who have three children or less. Moreover, the IUD seems to be the most popular method prescribed for women with three children or less.

Table 4.2a: Minimum Number of Children Needed Prior to Prescribing Family Planning

Family Planning Method	Mean	Minimum Number of Children Required						No Specific Number	Don't Know*
		0	1	2	3	4	≥5		
		%	%	%	%	%	%	%	%
Combined Oral Contraceptives	1.83	5.0	28.7	32.7	7.9	4.0	3.0	15.8	3.0
Progestin only pill	1.77	4.0	32.7	25.7	11.9	1.0	3.0	15.8	6.0
IUD	1.85	--	33.7	44.6	11.9	2.0	1.0	2.0	5.0
Depot-Provera	2.25	1.0	22.8	21.8	8.9	5.9	6.9	8.9	23.8
Norplant	3.06	--	10.9	8.9	7.9	10.9	9.9	5.9	45.4

*This category included those who reported not providing the service or did not respond

In examining the mean for the minimum number of children that a women should have prior to prescribing modern family planning methods, an average of 3 children was reported by providers as a requirement for prescribing Norplant to women. In addition, 45.4% of the providers reported not knowing or not prescribing Norplant, thus indicating a need to introduce complete and thorough awareness of this method at the primary health care level. Table 4.2b shows that with the exception of Norplant, at least 80% of providers who reported a specific minimum number of children for prescribing or referring women for modern family planning methods specified a minimum of three children.

Table 4.2b: Percent Distribution for Providers Specifying a Minimum Number of Children Required for Prescribing Family Planning

Modern FP Method	≤ 3	> 3	Total
Combined Oral Contraceptives	91.5	8.5	82
Progestin only Pill	94.9	5.1	79
IUD	96.8	3.2	94
Depot-Provera	80.9	19.1	68
Norplant	57.1	42.9	49

4.3 Restrictions for using modern family planning methods

Providers were asked about restrictions in providing modern family planning methods related to breast-feeding women and immediately postpartum (0-48 hours after delivery). Table 4.3 shows that the providers' knowledge to the provision of these methods in both situations is not extremely comprehensive and thorough. For instance, despite the lack of restriction on the use of IUDs, 43.6% of the providers reported having restrictions in providing or referring breast-feeding women for IUD insertion. This indicates that more than half of the providers are unaware of the fact that the IUD does not affect the quantity and quality of breast milk and is therefore ideal for breast-feeding mothers.

Table 4.3: Percent of Providers Reporting Restriction for Providing FP Methods to Breast Feeding Women and Immediate Postpartum

Family Planning Method	Breast Feeding Women	0-48 hrs Postpartum
Combined Oral Contraceptives	**87.1**	93.1
Progestin only Pill	**29.7**	85.1
IUD	**43.6**	**76.2**
Depot-Provera	63.4	92.1
Norplant	68.3	92.1

In addition, 76.2% of the providers reported restrictions for providing or referring women for IUD use immediately postpartum. This seems incongruent with the fact that insertion of the IUD high in the fundus (within 10 minutes after placenta delivery) allows for lower expulsion rates[4]. Responses further indicate that the providers are relatively knowledgeable regarding restrictions on the use of Combined Oral Contraceptives during breastfeeding due to their effect on the quality and quantity of the milk. The low response concerning restrictions on Progestin only pills during breast-feeding is parallel with the fact that these pills have no effect on breast milk production[5]. Since there are no restrictions for Depot-Provera and Norplant use while breast-feeding (six weeks after delivery), providers' knowledge regarding this issue seems to be mostly doubtful. However, responses seem inconclusive in light of not specifying the period of breast-feeding, and the intention to breast-feed postpartum when questioning the providers.

[4] Blumenthal, P.D. and McIntosh, N. (1996). Pocket Guide for Family Planning Service Providers 1996-1998.JHPIEGO

[5] Family Planning Methods and Practice: Africa, 2nd ed (1999), U.S. Department of Health and Human Services, 352.

Section 5: Specific Knowledge about Modern Family Planning Methods

The bolded percentages refer to situations where the identified method is not usually recommended unless other more appropriate methods are not available or not acceptable, OR where the method is not recommended for use (as identified in the medical eligibility criteria for contraceptive use of the WHO)[6].

5.1 Combined Oral Contraceptives and Progestin only Pills

Minimal differences were found between the percent of respondents who reported providing or prescribing the Combined Oral Contraceptives "COC" and the Progestin Only Pills "POP" (83.2% and 79.2% respectively). Providers were asked about the contraindications for prescribing Combined Oral Contraceptives and Progestin Only Pills, as well as the advantages and disadvantages that they would discuss with the client receiving each of these pills.

5.1.1 Contraindications

Table 5.1.1 shows the distribution of responses for related contraindication category. There is a clear knowledge deficit in the various contraindications for combined and Progestin only pills. With the exception of the phlebitis history as a contraindication for the Combined Oral Contraceptives, none of the contraindications for either of the hormonal pills exceeded a 49% response rate.

Table 5.1.1: Distribution of Responses on Contraindications of Combined Oral Contraceptives (COC) and Progestin Only Pills (POP)

Contraindication Category	COC(%)*	POP(%)*
History of phlebitis or embolus	**67.3**	21.8
Active smoking	**34.7**	3.0
History of breast cancer	**3.0**	**7.9**
Liver problems	**6.9**	**7.9**
Breast feeding (6 weeks postpartum)	**30.7**	**9.9**
Diabetes	**30.7**	40.6
Hypertension	**48.5**	46.5
Pregnancy	**5.0**	**9.9**
History of headaches	37.6	14.9
Women is over 35 years of age	17.8	10.9
Heavy menstruation	11.9	4.0
Undiagnosed vaginal bleeding	3.0	5.0
Seizure history (controlled by medication)	28.7	26.7
Other	10.0	9.0
No contraindications	--	2.0
Don't Know/No response	3.0	6.9
Total number of responses	***342***	***229***

* Percents are for responses from valid cases, Total does not add to 100%

[6] Improving Access to Quality Care in Family Planning: Medical eligibility criteria for contraceptive use. Second Edition. WHO. 2000.

An example of the knowledge deficit can be noted in the low mentioning of breast cancer history and hepatic problems as contraindications for both types of pills. Moreover, the substantial lower risk of stroke accompanying the use of the Progestin only pills as opposed to the Combined Oral Contraceptives among women with hypertension or diabetes was not demonstrated in the providers' responses. Alternatively, the factual increased risk of thrombosis accompanying the use of Combined Oral Contraceptives as opposed to the Progestin only pills, in women with a history of phlebitis, is reflected in the providers' responses.

5.1.2 Advantages and disadvantages

Providers were asked about the advantages and disadvantages discussed with the client when providing combined and Progestin only pills. Table 5.1.2a shows that effectiveness followed by resuming fertility were the most pronounced advantages identified by the providers for both methods. The absence of estrogen related side effects of the Combined Oral Contraceptives demonstrated by its protection against ovarian and endometrial cancer, and the breast-feeding advantages of the Progestin only pills were minimally noted by the providers.

Table 5.1.2a: Distribution of Responses on advantages of Combined Oral Contraceptives (COC) and Progestin Only Pills (POP)

Method	Advantage	%*
Combined Oral Contraceptives	Very effective	**91.1**
	Return to fertility	**32.7**
	Protects against uterine, and ovarian cancer	**23.8**
	Does not interfere with intercourse	23.8
	Cheap, safe or easy to use	13.0
	Decreases premenstrual symptoms	2.0
	Other	8.9
	No advantages would be discussed	1.0
	Do not know any advantages	3.0
	Total number of responses	***201***
Progestin Only Pills	Very Effective	**70.0**
	Return to fertility	**26.0**
	Can be used while breast feeding	**14.0**
	Protects against ovarian and cervical cancer	**7.0**
	Do not interfere with intercourse	21.0
	Can be used by women over 40 years of age	6.0
	Can be used by women who cannot take estrogen	2.0
	Reduces menstrual flow	1.0
	Cheap and affordable	1.0
	No advantages would be discussed	2.0
	Do not know any advantages	5.0
	Total number of responses	***162***

* Percents are for responses from valid cases, Total does not add to 100%

Disadvantages reported by the providers for the combined and Progestin only pills are shown in Table 5.1.2b. More disadvantages were stated for the Combined Oral Contraceptives. Headaches were acknowledged as a disadvantage that is more commonly experienced with Combined Oral Contraceptives. Other known disadvantages of the Combined Oral Contraceptives, such as; nausea, depression and weight gain were reasonably noted by the providers. Less than 20% of the providers identified the inconvenience of taking the Progestin only pill at the same time every day. Given that many of the side effects listed for the Progestin only pills are normally considered as disadvantages for the Combined Oral Contraceptives dictates an overall uncertainty in identifying the disadvantages of each method.

Table 5.1.2b: Distribution of Responses on disadvantages of Combined Oral Contraceptives (COC) and Progestin Only Pills (POP)

Method	Disadvantage	%*
Combined Oral Contraceptives	Headaches	**84.2**
	Weight gain	**72.3**
	Nausea	**50.5**
	Depression	**35.6**
	Cannot be used during breast feeding	18.8
	Spotting/bleeding	15.8
	Loss of libido	6.9
	May be inconvenient to use	5.9
	Pain in different parts of the body	5.9
	Causes nervousness	4.0
	Increased risk of cardiovascular problems	4.0
	Can cause cancer	3.0
	Can cause infertility	2.0
	Weight loss and Others	7.0
	Will discuss no disadvantages	2.0
	There are no disadvantages/Don't know	5.0
	Total number of responses	***326***
Progestin Only Pills	Need to take pill regularly or May be inconvenient to use	**19.8**
	Causes headache	39.6
	Bleeding/spotting	31.7
	Weight gain	30.7
	Causes depression	22.8
	Causes nausea	16.8
	Breast tenderness	5.0
	Can cause infertility	3.0
	May interact with medication	2.0
	Cost	1.0
	Other	7.9
	Will discuss no disadvantages	3.0
	There are no disadvantages/Don't know	8.0
	Total number of responses	***193***

* Percents are for responses from valid cases, Total does not add to 100%

5.1.3 Barriers

Providers were asked to state barriers that impede a wider and more effective use of combined and Progestin only pills. Table 5.1.3 shows that side effects and health concern were considered the greatest barriers for the Combined Oral Contraceptives. The second most important barrier was reported to be women's failure to remember taking the pill. Although of varying intensity, these two factors were also considered the most important barriers for the Progestin only pills. The return to fertility after using the method was considered a lesser barrier for the Combined Oral Contraceptives than the Progestin only pill.

Table 5.1.3: Distribution of Responses on Barriers of Combined Oral Contraceptives (COC) and Progestin Only Pills (POP)

Barrier	COC(%)*	POP(%)*
Health concern/fear of side effects	**50.5**	**39.6**
Women forget to take pills	**45.5**	**33.7**
Might cause cancer	17.8	15.8
Religious prohibition	14.9	9.9
Husband opposition	17.8	13.9
Leads to infertility	5.0	10.9
Lack of knowledge	17.8	16.8
Unnatural method	5.0	4.0
Other	8.9	20.8
No barriers exist	7.9	2.0
Don't know/No response	5.0	8.9
Total number of responses	***196***	***178***

* Percents are for responses from valid cases, Total does not add to 100%

Increasing the knowledge about the advantages and disadvantages of the combined and Progestin only pills, as well as the management of the various side effects can assist the providers in minimizing the perceived barriers. Identifying the side effects and the proper management of each is therefore crucial for an effective and wider provision of family planning methods.

5.1.4 Misconceptions

More providers reported hearing misconceptions or misinformation from the clients about Combined Oral Contraceptives than Progestin only pills (41.6% and 36.6% respectively). Table 5.1.4 lists the various misconceptions conveyed by the providers who reported hearing misconceptions.

Table 5.1.4: Distribution of Responses on Misconceptions about Combined Oral Contraceptives (COC) and Progestin Only Pills (POP)

Misconception	COC (%)*	POP (%)*
Causes high blood pressure or heart disease	31.0	24.3
Causes infertility	69.0	64.9
Causes cancer	73.8	62.2
Not effective	4.8	2.7
Causes side effects	7.1	N/A
Reduces breast milk	N/A	5.4
Other	19.0	5.4
Total number of responses/valid cases	***86/42***	***61/37***

* Percents are for responses from valid cases, Total does not add to 100%

Generally, perceptions heard by the providers were mainly health concerns. This indicates that providers tend to think that clients believe the pill causes specific health problems. The first health concern shown in table 5.1.4 (causes heart disease) refers to a correct perception that is largely restricted to smokers and women over 35 years of age as well as women with multiple risk factors, such as: hypertension, diabetes, and hyperlipidemia. The latter two (causes infertility and cancer) are misconceptions. Cancer perception of the pill might be one of the reasons for it's non-use among clients especially if its adverse and beneficial effects on cancer are confused. The high perception regarding cancer for both the combined and the Progestin only pills, as well as the infertility concern, suggest a need to study specific concerns and misconceptions among users.

5.2 Depot-Provera and Norplant

Overall, about 50% of the providers reported neither providing nor referring clients for Depot-Provera. With only one provider reporting Norplant provision, 75% of the providers reported neither providing nor referring clients for this method. It is noteworthy to mention that only 15.8% of the providers reported receiving training in Norplant insertion within the past 5-year period.

5.2.1 Advantages and disadvantages

Providers were asked to mention advantages and disadvantages that they would discuss with women inquiring about Depot-Provera and Norplant.

Table 5.2.1a suggests that effectiveness and long-term protection of both Depot-Provera and Norplant were the two most accounted for advantages. Of special concern is the advantage (husband doesn't have to know) of Depot-Provera, which is a sensitive issue rather not suitable as an advantage. The table further shows that the proportion of providers who mentioned not knowing anything about Norplant outweighed that for Depot-Provera (28.7% and 8.1% respectively). On the other hand, proportion of providers not knowing any advantages about either method were close (13.9% and 12.9% for Depot-Provera and Norplant respectively). This indicates that there is an overall

deficiency in knowledge regarding the advantages of both methods, which might indirectly indicate low awareness.

Table 5.2.1a: Distribution of Responses on advantages of Depot-Provera and Norplant

Method	Advantage	%*
Depot-Provera	Very effective	**59.4**
	Can be used during breast feeding	21.8
	Offers 3 months of protection	16.8
	Protects against uterine and ovarian cancer	13.9
	Husband does not have to know	11.9
	Convenient to use, affordable	11.9
	Does not interfere with intercourse	10.9
	Do not know anything about the method	8.9
	Other	2.0
	No advantages discussed	2.0
	Don't know any advantages	13.9
	Total number of responses	***175***
Norplant	Long term protection	**40.6**
	Very effective	33.7
	Do not know anything about the method	**28.7**
	Protection starts within 24 hours of insertion	20.8
	Can be used during breast feeding	19.8
	No delay in fertility return	2.0
	Easy to insert and remove	1.0
	Other	2.0
	No advantages discussed	2.0
	There are no advantages/Don't know	12.9
	Total number of responses	***165***

* Percents are for responses from 101 valid cases, Total does not add to 100%

Table 5.2.1b indicates that menstrual irregularities and the slow return to fertility were the two most frequently noted disadvantages for the Depot-Provera. A lack of knowledge towards Norplant's advantage of its reversible effect was indicated by 19.4% of the providers. Given the low level of training in the insertion and removal of Norplant among the providers, the technical difficulty accompanying this procedure seems to be an underestimated disadvantage (8.3%). Moreover, breast tenderness, mood changes and nervousness are some of the common disadvantages of both Depot-Provera and Norplant that were not reported by the respondents.

Table 5.2.1b: Distribution of Responses on Disadvantages of Depot-Provera and Norplant

Method	Disadvantage	%*
Depot-Provera	Menstrual irregularities (spotting, bleeding, amenorrhea)	**76.0**
	Slower return to fertility	**53.3**
	Weight gain	30.4
	Causes infertility	8.7
	Inconvenient to use	6.5
	Other	5.5
	No advantages discussed	1.1
	No response/Don't know	10.8
	Total number of responses/valid cases	***177/92***
Norplant	Menstrual irregularities (spotting, bleeding, amenorhea)	50.0
	Immediate discontinuation is not possible	**30.6**
	Delay in fertility return	**19.4**
	Weight gain	13.9
	Difficult to insert and remove	8.3
	Causes infertility	4.2
	Other (headaches, hypertension....)	13.9
	No advantages discussed	1.4
	No response/Don't know	18.1
	Total number of responses/valid cases	***115/72***

* Percents are for responses from valid cases, Total does not add to 100%

Comprehensive and thorough awareness of the advantages and disadvantages of modern family planning methods can assist the provider in assessing limitations and usefulness of these methods. Increasing knowledge level of the providers relevant to disadvantages of Depot-Provera and Norplant can therefore improve counseling and provision of these methods.

5.2.2 Barriers

Providers were asked to mention barriers that impede a wider and more effective use of Depot-Provera in Jordan. Table 5.2.2a shows that the most commonly mentioned barriers were misinformation (32.7%) and lack of information (28.7%). Thirteen percent of the providers identified "a result in infertility" as a barrier to the use of Depot-Provera, which might be a misconception for the slower return to fertility disadvantage of this method. Barriers related to family and personal factors (such as husband's opposition and refraining from praying) were of considerable value.

Table 5.2.2a: Distribution of Responses on Barriers of Depot-Provera

Barrier	%*
Misinformation	**32.7**
Lack of information	**28.7**
Husband opposition	16.8
Refrain from praying	15.8
Causes infertility	**12.9**
Inconvenient	10.9
Effect on menstruation	8.9
Refrain from sexual activity	7.9
Cost	3.0
Causes cancer	3.0
Other	3.0
No barriers exist	2.0
Don't know/No response	13.9
Total number of responses	***161***

* Percents are for responses from valid cases, Total does not add to 100%

While almost half of the providers (47.5%) reported not knowing any institutional barriers to Norplant, a third of them (33.7%) were able to identify the barriers shown in Table 5.2.2b. Meeting the pronounced training needs identified by the respondents as barriers facing them in providing Norplant is crucial. Training in the insertion and removal of Norplant as well as in counseling for this method is of utmost importance if marketing the Norplant method is to be considered.

Table 5.2.2b: Institutional Barriers for Norplant

Barrier	%*
Unavailable equipment	57.6
Service provider knowledge	**75.8**
No training in insertion	**72.7**
No training in removal	**75.8**
No training in counseling	36.4
Not available in the private sector	12.1
Total number of responses/valid cases	***109/33***

* Percents are for responses from valid cases, Total does not add to 100%

Overall, the results show that there is a crucial need to provide training for Depot-Provera and Norplant provision. Increasing providers' knowledge and skills is a priority for a wider and more effective promotion of long-term family planning.

5.3 Tubal Ligation

Results showed that counseling provision for Tubal Ligation was reported by 46.5% of the respondents. However, provision of counseling was reported by 6% when physicians where asked to mention family planning methods that they counseled for during the preceding year. With none of the physicians reporting prescribing or performing Tubal

Ligation during the year preceding the survey, only one respondent reported ever performing this procedure. Moreover, less than one third of the providers (30.7%) said that they refer women for Tubal Ligation mainly for medically indicated situations (87.1%). Other reasons for referral included that for when the family size is complete (48.4%) or according to the wishes of the clients (3.2%).

5.3.1 Knowledge of indications for Tubal Ligation

Providers were asked to mention medical and non-medical indications for Tubal Ligation. Table 5.3.1 shows that heart disease was considered by the providers the number one medical condition necessitating Tubal Ligation. Grand multiparity was considered both a medical and a non-medical condition indicating Tubal Ligation. Repeated C-Sections and hypertension were considerably reported as medical conditions requiring Tubal Ligation (55% and 46% respectively). Providers who reported repeated C-sections as a medical indication for Tubal Ligation reported an average of 4.27 C-Sections. Other minimally reported medical conditions included: diabetes, history of genetic disease, liver/kidney problems, eclampsia, cancer, disease in the uterus and failure of other family planning methods.

Table 5.3.1: Indications for Tubal Ligation

	Condition	%*
Medical	Heart disease	**70.0**
	Repeated C-Section	55.0
	Hypertension	46.0
	Grand multiparity	**43.0**
	Other	30.0
	Don't know/No response	8.0
	Total number of responses/valid cases	**252/100**
Non-Medical	Completed family size	50.5
	Client's request	40.6
	Grand multiparity	**35.6**
	Woman's age	5.9
	Economical factor (poverty)	3.0
	Other	2.0
	None existing	12.9
	Don't Know	7.9
	Total number of responses/valid cases	**160/101**

* Percents are for responses from valid cases, Total does not add to 100%

The most commonly reported non-medical conditions indicating a need for Tubal Ligation were those related to the number of children and family size. Client's request was also indicated for as a common non-medical indication for Tubal Ligation.

5.3.2 Grand Multiparity

Providers were asked to numerically define grand multiparity. Answers were provided by 61.4% of the providers with an average of 4.79 children and a range of 6 (minimum 2, maximum 8 children). While a third of the providers (38.7%) were unable to numerically define grand multiparity, only 20.8% gave the number 4 and 21.8% the number 5 children as a response to this definition.

If grand multiparity is defined as parity > 4[7], then only 55.5% of the providers were able to correctly define this condition. Correctly defining and identifying grand multipara women is important in meeting family planning demand for high risk groups.

5.3.3 Criteria for Tubal Ligation

Providers were asked if a minimum age is required for women seeking Tubal Ligation. Less than half of the providers (45.5%) reported a minimum age requirement that ranged between 25 and 45 years with an average of 34.93 years. About 45% of the providers gave 4.7 children (range 3 to 8) as the average number of children required before a woman seeks Tubal Ligation. A higher average for the minimum number of boys than for girls was given (2.6 and 1.9 respectively).

Table 5.3.3: Criteria for Tubal Ligation identified by Providers

Criteria	%*	Min	Max	Mean
Minimum age of woman	45.5	25	45	34.93
Minimum number of Children	44.6	3	8	4.67
Minimum number of boys	60.4	1	4	2.64
Minimum number of girls	52.5	1	3	1.89

* Percent of Providers giving a numerical response

5.3.4 Counseling

Providers were asked to note information that should be offered to couples before agreeing to Tubal Ligation. Most of the providers (89.1%) reported telling the couples that Tubal Ligation is a permanent procedure that will disable childbearing. Almost all of the information reported by providers concentrated on the negative effects of Tubal Ligation. The other category displayed in Table 5.3.4 includes information resembling advantages of Tubal Ligation (doesn't affect sexual activities, very effective and doesn't

Table 5.3.4: Information Given to Couples Prior to Consenting to Tubal Ligation

Information	%*
TL is a permanent method	**89.1**
TL is a surgical procedure	29.7
Other temporary methods are available	28.7
Causes family problems	22.8
Can change mind before performing TL	13.9
There is a possibility of failure	10.9
TL is haram	7.9
Side effects are possible	6.9
Causes post-sterilization syndrome	4.0
Warning signs	3.0
Causes bleeding problems	3.0
Other	3.0
Don't tell anything	1.0
Don't Know/No response	1.0
Total number of responses/valid cases	***230/101***

* Percents are for responses from valid cases, Total does not add to 100%

[7] This is a supposition. Setting the level for grand multiparity can best be decided by a national panel of public health and obstetric experts. The cut-off-point for the level of grand multiparity should be adjusted to country settings and experience. Based on rural and urban differences, different levels of grand multiparity within a country may be necessary. (Antenatal Care. Report of a Technical Working Group, WHO, 1994)

affect woman's natural function).

Overall, providers tend to limit information about Tubal Ligation within the disadvantages of the procedure. Training in counseling and information provision is needed in order to assist in marketing Tubal Ligation as an effective long term family planning method.

5.3.5 Barriers

Table 5.3.5 lists the various barriers that hinder a woman from accepting Tubal Ligation. Most of these barriers are related to cultural values, religious beliefs, or personal obstacles. Providers commonly noted husband's remarriage and fear from divorce. Only 5.9% of the providers reported having institutional or clinical barriers in the provision of Tubal Ligation in Jordan. These barriers were minimally recorded as: unavailable equipment, provider's knowledge, training in counseling, cost and fear of physician from performing the procedure.

Table 5.3.5: Barriers for Tubal Ligation

Barrier	**%***
Husband will remarry	**70.3**
It is haram	**42.6**
Husband will divorce woman	**37.6**
Culturally unacceptable	36.6
Fear of surgery	34.7
Hospital stay	9.9
Woman can feel deficient	4.0
Fear of regret	3.0
Can cause side effects (weight gain, spotting…)	1.0
Other	2.0
Don't know/No response	3.0
Total number of responses/valid cases	***247/101***

* Percents are for responses from valid cases, Total does not add to 100%

In conclusion, providers think that barriers facing the provision of Tubal Ligation are mostly related to the cultural, religious and personal beliefs of women. Training in counseling for Tubal Ligation can assist the providers in assuming a better role in educating the public about this method and about the risks of multiparity.

Section 6: Attitudes about Family planning

6.1 Religious Beliefs

Providers were asked about their religious beliefs for modern family planning methods. They were asked to state whether they considered each mentioned method to be Halal (acceptable by Islam), Makrouh (not explicitly forbidden but undesirable) or Haram (disapproved by Islam).

Table 6.1: Percent Distribution for Providers by Religious Belief of Modern Family Planning Methods

Method	Halal	Makrouh	Haram	Don't Know
Pills	90.1	--	3.0	6.9
Depot-Provera	80.2	2.0	4.0	13.9
IUD	90.1	1.0	1.0	7.9
Condom	90.1	--	1.0	8.9
Norplant	**67.3**	1.0	5.9	25.7
Female Sterilization	**40.6**	1.0	**34.7**	23.8

Results in Table 6.1 show that more than a third of the providers believed that female sterilization is Haram. In addition, at least two thirds of the providers think of the modern family planning methods (other than Tubal Ligation) to be acceptable to Islam. The percentage of providers who were uncertain of the religious belief for Norplant and Female sterilization was significantly higher than that of other methods.

Religion is an important factor that affects the individual's perception of family planning. Exposure to knowledge about family planning is vital in determining the religious beliefs of individuals. Therefore, minimizing the knowledge deficit regarding the barriers, use and advantages of long-term family planning methods is crucial for creating a wider perspective and a different belief for these methods.

6.2 Selected Beliefs and Attitudes

Providers were asked to specify their agreement with given statements reflecting certain beliefs and attitudes towards specific family planning methods. Table 6.2 shows that about two thirds of the providers (65.3%) believed that men are the primary decision makers in family planning, and that acquisition of a spousal consent prevents women from getting a Tubal Ligation (66.3%). In addition, nine out of ten providers agreed that even with the husband's consent, a woman who gets a Tubal Ligation might face family problems.

About half (52.5%) of the providers agreed that it is more important to manage side effects than to discontinue using a modern family planning method, and 71.3% agreed that natural family planning is not the best contraceptive method. These results indicate that providers tend to favor modern family planning methods despite the encountered side effects. With two thirds of the providers noting that it is better for physicians not to perform Tubal Ligation (fearing women's regrets), fourty percent said that they do not feel comfortable discussing this method with clients.

Table 6.2: Agreement with Selected Statements about Family Planning Methods

Statement	Agree	Disagree	Don't Know
If a woman has a Tubal Ligation even with her husband's consent, she may face family problems.	89.1	7.9	3.0
Because women often regret having a Tubal Ligation, it is better that physicians do not perform this procedure.	**67.3**	24.8	8.0
Norplant is a safe contraceptive method.	**40.6**	22.8	**36.7**
I do not feel comfortable discussing Tubal Ligation with clients.	**40.6**	43.6	15.9
Depot-Provera can lead to infertility.	**41.6**	39.6	18.8
It is more important to manage side effects than to discontinue using a modern method of family planning.	52.5	36.6	10.9
Men are the primary decision makers in family planning.	**65.3**	31.7	3.0
Women using Depot-Provera who experience spotting cannot pray.	21.8	49.5	28.7
A couple has completed their family. The mother is 31 years. They do not want any more children. Tubal Ligation is an appropriate method for this family.	**19.8**	75.3	6.0
Requiring spousal consent prevents women from getting a Tubal Ligation.	66.3	21.8	11.9
A couple has 6 daughters and no sons. They do not want any more children. Tubal Ligation is an appropriate method for this family.	**8.9**	88.1	3.0
Natural family planning is the best contraceptive method.	24.8	71.3	4.0

As opposed to Depot-Provera, Norplant is viewed as a safe contraceptive method. Therefore, providers seem to accept and agree with the use of Norplant as a long term contraceptive, more than Depot-Provera, which is believed to cause infertility.

Generally, results indicate that providers tend to believe in modern family planning methods more than natural methods. Tubal Ligation does not seem to be a preferred method even if it is performed with consent and approval of the clients. Perhaps the tendency to distance Tubal Ligation stems from its irreversible effects and the psychological barriers encountered with the decision of having it done.

Section 7: Conclusion and Recommendations

The overall training received by providers in this study was found to be very minimal. The most commonly prescribed family planning method was contraceptive pills. Norplant and Depot-Provera were found to be provided or prescribed minimally for both women and couples, and for families who have completed their family size or who wished to delay their first-born. Providers tend to restrict the use of Norplant and Depot-Provera. Furthermore, Tubal Ligation seems to be isolated and ignored by a large number of providers. The following recommendations are presented in an effort to promote the use of modern family planning methods.

1. **Increase the providers' knowledge of modern family planning methods, particularly Norplant and Depot-Provera.** The fairly recent introduction of Norplant seems to play an important role in its provision. Thorough awareness of the advantages and disadvantages of modern family planning methods can assist the provider in assessing limitations and usefulness of these methods. Providing training with particular emphasis on the use and limitations of Norplant and Depot-Provera is crucial for promoting these family planning methods as long-term methods. Thorough comprehension of side effect management for family planning methods can assist the provider in gaining confidence when offering counseling. Moreover, discontinuation of family planning methods can be minimized if knowledge deficits and gaps are constricted.

2. **Develop opportunities for marketing Tubal Ligation among couples or men.** Providers tend to ignore and alienate Tubal Ligation when discussing family planning with couples or men. Increasing the knowledge of this procedure in terms of use, side effects, and counseling can assist the provider in furthering its promotion as an effective long-term method. Misconceptions and fears of disrupting family unity seem to play a major role in providing or prescribing Tubal Ligation. Therefore a carefully designed information-education-communication (IEC) program about Tubal Ligation can relieve some of the stress and fear encountered with the decision to perform this procedure.