

THE MINISTRY OF PUBLIC HEALTH

*Cameroon: Measuring Adherence of
Service Providers to the National
Maternal and Child Health/Family
Planning Service Guidelines*

Final Report

October 1995

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I. INTRODUCTION

A. Background and Rationale

Increasing access to family planning and improving the quality of service provision include the reduction of medical barriers to contraception. Medical barriers are "...practices, derived at least partly from a medical rationale that result in a scientifically unjustifiable impediment to, or denial of, contraception" (Shelton, 1992). Many medical barriers are rooted in the outdated beliefs that contraceptives are unsafe and that clients need to be monitored frequently.

In 1992 the Ministry of Public Health/Directorate of Family and Mental Health (MOPH/DFMH) of Cameroon, with assistance from the Program for International Training in Health (INTRAH), listed potential medical barriers in Cameroon and developed scientifically justifiable medical policies designed to reduce their incidence. The primary rationale for this initiative was based on the assumption "...that the removal of unnecessarily restrictive policies and practices will increase use of contraceptive methods without compromising the health status of the user" (Bertrand, 1994). Examples of the medical barriers listed included eligibility criteria such as age, parity and marriage restrictions, and "process hurdles" such as unnecessary lab tests and proof of spousal consent.

In an effort to improve both the quality of and access to family planning services, the MOPH/DFMH and INTRAH created a set of national service delivery guidelines consisting of two documents. The Maternal and Child Health/Family Planning (MCH/FP) Service Policy and Standards was intended for family planning program managers and providers and was designed to standardize family planning practices by outlining general rules of service provision for clinic staff. The MCH/FP Medical Protocols document was intended specifically for service providers and was designed to provide step-by-step guidance in how to apply the Policy and Standards document to particular clinical service procedures.

The MCH/FP Service Policy and Standards document was distributed by the MOPH/DFMH and the SEATS Project of John Snow Inc. (JSI) in June, 1993 to every family planning service delivery point in Cameroon. In November, 1993 the MOPH/DFMH, INTRAH and Family Health International (FHI) held a national dissemination seminar to introduce the Policy and Standards document to family planning program managers and clinic directors. Also in 1993, a draft version of the Medical Protocols was distributed to many family planning clinics. Eight months after this document was distributed the MOPH/DFMH, INTRAH and FHI conducted a series of dissemination seminars in five provinces to train family planning service providers in the use the final version of the Medical Protocols.

In response to a request by the MOPH/DFMH, INTRAH invited FHI to conduct a study to measure provider adherence to the guidelines. This study was coordinated with INTRAH's Phase III training activities and was conducted under the direction of Professor Paul Nkwi of the Pan-African Association of Anthropologists (PAA) and the MOPH/DFMH. INTRAH

assisted the PAA and FHI with the development of the study protocol and the data collection instruments.

B. Objectives

The objectives of the study were to:

1. measure service provider adherence to the guidelines after their distribution but before the dissemination seminars;
2. measure service provider adherence to the guidelines after the dissemination seminars;
3. identify reasons for non-adherence to the guidelines; and
4. determine the impact of changes in provider practices on the distribution and acceptance of family planning methods.

The study focused on the following medical barriers identified by the MOPH/DFMH and INTRAH:

1. Family planning methods denied to unmarried young women

Minimum age and marriage requirements at family planning clinics are generally enforced in the belief that access to contraception leads to promiscuity among young women. However, it is widely acknowledged that increasing access to contraception does not increase sexual activity in young women.

2. Injectables and oral contraceptives (OCs) restricted to clients on the basis of parity, age and weight

The belief that low parity clients should be restricted from access to injectables is based on erroneous eligibility criteria. Parity restrictions often exist because providers mistakenly fear that injectables cause infertility or delay return to fertility. However, injectables do not cause permanent infertility and that the return to fertility after termination of injectables is only slightly longer than for oral contraceptives (OCs) (Pardthaisong, 1984). Other barriers are restrictions of OCs based on age and weight. Maximum age and weight limits often exist because providers are concerned that OCs will put older or heavier clients at risk of cardiovascular diseases. Years ago this concern was valid. However, since the advent of the low-dose combined pill, women can safely take OCs throughout their reproductive life and regardless of their weight (Hatcher, 1994).

3. **Proof of spousal consent required for reversible contraception**

Requiring clients to present proof that their spouses approve of method choice can be threatening to women's lives and health because of the increased risk of domestic violence (Cook, 1987). Some common reasons for this requirement are that providers worry about being blamed by spouses for providing contraceptives and fear that, without the spousal consent rule, husbands may accuse their wives of infidelity.

4. **Unnecessary laboratory tests required for family planning methods**

Routine laboratory testing of clients before the provision of contraception is not recommended (Buekens, 1990). The utility of these tests is questionable in light of the low prevalence of contraindications, poor lab facilities, and prohibitively high costs usually borne by the client (Stanback, 1994). The most common blood test, that for hemoglobin, is useful for prescribing IUDs, but not indicated for combined pills, which have been shown to increase hemoglobin levels in anemic clients (Rivera, 1983). The utility of other common lab tests such as those for kidney function (albumin), urine sugar (glucose) and sickle cell are also questionable (Buekens, 1990).

5. **Restrictions on the number of OC cycles provided**

Experts agree that as many as 13 cycles of pills can be provided at a client's initial visit and at each follow-up visit. Providers, however, should encourage a 3-month follow-up counseling visit with new acceptors to assess whether clients are using the method correctly. Revisiting clients should be encouraged to return to providers annually or whenever they have problems, concerns, or questions. (Technical Guidance Working Group, 1994).

6. **Pelvic exams required before provision of hormonal methods**

Although pelvic exams are necessary for certain services, such as IUD insertion, they are not routinely needed for the safe use of hormonal methods (Grimes, 1993). Community-based distribution programs for oral contraceptives do not require pelvic exams, nor do many clinic-based programs. This is consistent with a public health approach to service provision which shows that women who do not have a medical exam before starting OCs are not at increased risk of pill-related problems (Miller, 1987).

C. Description of Guidelines and Dissemination Activities

The Policy and Standards document provides guidance to family planning program managers regarding the types of services family planning programs should provide, the types of methods and equipment which should be available at various service delivery points, and who

should have access to family planning services. With specific regard to the medical barriers listed above, the Policy and Standards addresses barriers 1 through 3. The document states that 1) all women of reproductive age should have access to barrier methods and OCs, 2) all women of reproductive age, except adolescents, should have access to injectables and 3) a partner's consent is not required before receiving contraception. The document does not refer to parity or weight restrictions (except for IUDs), implying that hormonal methods should be provided regardless of parity or weight.

The Medical Protocols document provides guidance on how to conduct different types of family planning consultations (initial and revisit) and how to provide different contraceptive methods (i.e. inserting an IUD). Included in this document are guidelines for prescribing methods, for identifying contraindications and for diagnosing and treating side effects. With specific regard to the medical barriers listed above, this document addresses barrier 5 (OC cycles provided) and states that new clients are to receive three cycles of pills, and revisiting clients are to receive at least six cycles.

Neither document specifically refers to medical barriers 4 (laboratory tests) or 6 (pelvic exams). The Medical Protocols refer to various occasions when pelvic exams and laboratory tests should be performed (for example in diagnosing an STD or determining a pregnancy); however neither document states that pelvic exams or laboratory test are not to be routinely performed.

During the course of the study, it became apparent that some clients were denied access to OCs because of a barrier that had not been identified in the list above. This barrier was the requirement that a woman be menstruating before receiving pills. The Medical Protocols document, however, does refer indirectly to this barrier. It states that clients should begin combined OCs on the first day of menses. This implies that pills can be prescribed at any time. Furthermore, the document states that pregnancy tests should be conducted only when clinical signs are present, implying that it is not necessary to be menstruating during a clinic visit in order to receive contraception.

The dissemination seminars were designed to convey the information in both documents to service providers. Specific emphasis was placed on training the providers to use the Medical Protocols document. Each of the five dissemination seminars was three days long, and included two and one-half days of lectures and discussion of the content of the guidelines and one-half day on case studies designed to reinforce the didactic material. During the half day sessions small groups discussed various case studies. For example, some providers were asked how they would treat a married 33 year-old woman with five children, who had been on DEPO-PROVERA for one year, and returned to the clinic ten days after her scheduled visit for a follow-up injection and had been amenorrheic since her last injection. After discussing how they would have treated this client, the providers were asked to compare their decisions with the Protocols.

II. METHODOLOGY

A. Introduction

This study used a pre-test/post-test design in which data were collected before and after the dissemination of the guidelines. Although a stronger design would have included a control group, such a design was not used because the MOPH/DFMH felt that it would have been unethical to withhold training in the use of these documents.

The study was carried out in ten clinics in four provinces evenly distributed between French and English speaking Cameroon. Four sites were chosen in the Central province while two sites each were chosen in the Littoral, South West, and North West provinces. Assuming that trends in provider practices would be similar in all clinics, we selected study sites with the largest case loads. These study sites also attracted the largest number of new clients, which were the principle target group of the study since they represent the group most likely to face medical barriers.

B. Data Collection Instruments

A number of data collection sources were used to determine the magnitude of barriers prior to and following the dissemination seminars. Information was collected from the following sources:

1. Client interviews provided data on client experiences and provider practices. Data were collected on:
 - a. client characteristics (age, parity, marital status, etc.)
 - b. the method of contraception that the client desired and actually received
 - c. experiences with service providers
 - d. previous contraceptive use
2. Service provider interviews yielded information on general practices and procedures from providers from each study site, including those who had not been trained in the use of the documents. Interviews were conducted with thirteen service providers who attended dissemination seminars of the MCH/FP guidelines. Nine providers, who were invited to the dissemination seminars but did not attend, were also interviewed.
3. Client records kept for all women receiving modern contraceptive methods except for those receiving condoms or spermicides were reviewed. The records contain information such as age, marital status, parity, exams and laboratory tests performed, methods desired by clients and methods provided.

4. Daily registers provided information on the number and types of contraceptive methods provided as well as the number and types of visits (either new or revisiting).

C. Problems Encountered/Data Collection Period

Two unforeseen events forced the study team to alter its original data collection plan. First, the dissemination seminars were postponed for one month, delaying the follow-up data collection. Second, the USAID/Cameroon Mission ordered all projects to cease activities in June, 1994 in preparation for its close-out. The closure reduced the follow-up data collection period to only three months. As a result of these events, FHI conducted one, instead of two, sets of follow-up client interviews.

In addition, the researchers had to conduct the provider interviews simultaneously with the follow-up client interviews. This change meant that researchers were not able to use information from the follow-up client interviews to ask individual providers about specific reasons for not following the guidelines. Instead, providers were asked questions regarding general medical beliefs and practices.

Clients were interviewed at each study site for two-week periods during both the baseline and follow-up data collection periods, while providers were interviewed immediately after the follow-up client surveys. Since the scope of the provider interviews was reduced, this report does not rely heavily on this information. (Complete results are shown in Appendix A.)

Client records were selected, randomly, one day per week over a 16-month period in each study site. Data from this source were not as useful as anticipated for two reasons: 1) the records were inconsistently filled out, and 2) they were not completed for new clients who did not receive hormonal methods or IUDs. As a result this information was not included in this report.

The daily registers in each study site were aggregated by month and collected over a 16-month period. Information from this source was not included in this report because not enough data could be collected due to the premature termination of study activities discussed above.

III. RESULTS

A. Introduction

The results from the client interviews are the primary source of analysis in this section. Interviews were conducted with 662 women during the baseline survey and with 597 women in the follow-up survey. This report is generally concerned with women seeking family planning for the first time. However, some analyses address both new and revisiting clients because certain medical barriers apply to both groups. Table 1 provides comparative background information on new and revisiting clients.

TABLE 1. General Client Characteristics

CHARACTERISTICS	BASELINE		FOLLOW-UP	
	NEW	REVISITING	NEW	REVISITING
Mean Age	26.1	28.5	26.3	29.1
Mean Parity	3.4	4.1	3.3	4.1
Nulliparous %	12.1	6.2	8.1	3.4
≤ Six Months Post-partum %	16.4	5.7	13.7	4.4
Over 70 Kgs %	25.0	26.6	31.3	29.4
Married %	59.5	70.3	56.5	71.7
Number of Clients	116	546	124	473

Comparison of new client characteristics in both the baseline and follow-up surveys in table 1 indicate that there are no significant differences between the two groups ($p > .05$ in all comparisons).

Table 1 also indicates that new clients were more likely than revisiting clients to be younger, to have fewer children, to be less than six months post-partum, to never have had a live birth, and to be unmarried ($p < .05$ in all comparisons).

The following sections are organized to highlight groups of barriers that:

- were prevalent and were reduced
- were not prevalent
- were prevalent but were not reduced
- were prevalent in baseline survey but no determination could be made as to whether they were prevalent in the follow-up survey
- had been previously unidentified
- were barriers whose existence could not be determined

B. Barriers That Were Prevalent and Were Reduced

1. The restriction on the number of OC cycles provided to new clients

According to the guidelines, clients should receive at least three OC cycles on initial visits. In the baseline survey the mean number of cycles provided to 53 new clients was 1.96. This number increased to 2.41 in the follow-up group of 44 new clients (one-tail T-test $p < .05$). Furthermore, in the baseline survey 44 percent of new clients who received pills obtained three or more cycles compared with 66 percent in the follow-up. This rise clearly indicates that most providers adapted to the guidelines.

Regard to OC cycle provision, data obtained from the service provider interviews indicates that there is little difference between providers who attended the dissemination seminars and those who did not. Among those who attended the seminars, ten of thirteen said that they provided three or more cycles of OCs to new clients compared with six of nine who did not attend (Appendix A, Table 1a).

C. Barriers That Were Not Prevalent

There were two barriers that proved to be too unimportant. One was the requirement of spousal consent before receiving a reversible contraceptive method. In both the baseline and the follow-up surveys, only a small percentage of new clients said that they were required to prove that they had their spouse's consent (7.8 percent in the baseline and 4.0 percent in the follow-up). Comparison of the baseline and follow-up results showed that the difference between the two groups was not significant ($p = .3$). This barrier did not decrease significantly because it was not prevalent in the baseline survey.

The second barrier was the requirement that laboratory tests be completed in order to receive family planning methods. Our results showed that, in the baseline survey, only 9.5 percent of the new clients had laboratory tests compared to 14.5 percent in the follow-up survey. Again, there was no significant difference between the two surveys ($p = .3$).

Results of the provider interviews confirmed that these barriers were not prevalent (Appendix A, Tables 2, 3a, 3b).

D. Barriers That Were Prevalent But Not Reduced

1. The restriction on the number of OC cycles provided to revisiting clients

The guidelines specify that revisiting clients should receive six or more OC cycles per visit. However, results from the client interviews indicate that these clients received far fewer cycles per visit. In the baseline survey, the mean number of cycles provided to revisiting clients was 2.98 compared to 3.00 in the follow-up survey.

Providers said that they provide more cycles of OCs to revisiting clients than they actually do. Seven of thirteen who attended the dissemination seminars stated that they provide six or more OC cycles to revisiting clients. Only one of the providers who did not attend the seminars claimed to provide six or more OC cycles (Appendix A, Table 1b).

When asked to explain why they do not provide more cycles, many of the providers in both groups stated that they prefer to consult with their clients every three months to determine that they are taking the pills correctly.

E. Barriers That Were Prevalent in Baseline Survey but No Determination Could Be Made As to Whether They Were Prevalent in Follow-up

1. Hormonal methods restricted to clients on the basis of parity, age, and weight

The guidelines state that all fecund women should have access to hormonal methods unless they are medically contraindicated. This section evaluates whether restrictions were placed on the distribution of injectables and OCs based on parity, age, or weight.

a. Parity

Results from recent FHI studies in Ghana and Kenya indicate that many service providers fear that injectables may cause infertility (Stanback, 1995). Consequently, they are reluctant to provide injectables to childless or low parity women. The guidelines do not refer to parity in the discussion of eligibility criteria for injectables.

Table 2 shows the distribution of injectables to new clients in both baseline and follow-up surveys according to the number of live births. The percentage of women who received injectables in the baseline survey was associated with the number of live births ($p = .01$); women with three or more births were over three times as likely to receive injectables as were women who had less than three births. However, in the follow-up survey, the association between the number of live births and provision of injectables was not significant

at the .05 level ($p = .2$). During the follow-up data collection period, the supply of hormonal methods was limited and few women received injectables. It is therefore difficult to determine whether providers intended to change their practices.

TABLE 2 Percentage of New Clients Who Received Injectables by Number of Live Births

INJECTABLES PROVIDED	NUMBER OF LIVE BIRTHS	
	0 to 2	3 or More
BASELINE		
Yes (%)	8.2	29.7
Number of New Clients	49	64
FOLLOW-UP		
Yes (%)	2.0	7.1
Number of New Clients	51	70

However, results of the provider interviews indicate that there is little difference in attitudes of providers regarding provision of injectables according to attendance at the dissemination seminars. Providers who attended the seminars required that their clients have an average of 2.08 live births before they would provide injectables, while providers who did not attend the seminars required an average of 2.00 live births (Appendix A, Table 4). Thus, there is some indication that providers did not intend to change their practices.

b. Age

Many providers are concerned that older women who take pills run a high risk of cardiovascular failure. According to Hatcher, "Age is not a reason to avoid pills ... in women toward the end of the reproductive lifespan." (Hatcher, 1994) The guidelines make no specific reference to maximum age limits for method provision but say that all women of reproductive age have right to OCs.

Table 3 shows the percentage of new clients who received OCs in both baseline and follow-up surveys according to age. The baseline survey indicates a strong association between pill provision and age ($p = .007$); new clients under 30 were almost twice as likely to receive pills as were clients 30 and over. Results from the follow-up survey, however, indicate no association between age and pill provision ($p = 0.4$). Method stockouts referred to above affected provision of OCs making it difficult to determine whether providers intended to change their practices.

TABLE 3 Percentage of New Clients Who Received OCs by Age

OCs PROVIDED	AGE	
	15 to 29	30 and over
BASELINE		
Yes (%)	57.7	29.4
Number of New Clients	78	34
FOLLOW-UP		
Yes (%)	38.6	30.6
Number of New Clients	83	36

However, results of the provider interviews indicate that the seminars did significantly affect providers' attitudes regarding age and OC provision (one-tailed T-test $p < .05$). The maximum average age allowed for provision of combined OCs was 40 for those who attended the seminars compared with 36 among providers who did not attend the seminars. Thus, there is an indication that providers intended to modify, but not eliminate, age restrictions for OCs.¹

c. Weight

Another potential barrier to provision of OCs is maximum weight restrictions. However, it was not possible to analyze the impact of changes in this barrier because a large number of women were not weighed.

2. Pelvic exams required before the provision of hormonal methods

Routine pelvic exams for women interested in using hormonal methods are considered medically unnecessary. Although the Medical Protocols indicate when it is appropriate for providers to perform pelvic exams, the document does not specifically state that providers are not to perform them on a routine basis. This section evaluates whether there were changes in the proportion of women receiving these exams, and if so, whether those changes increased access to contraception.

¹ It is not clear whether the association of parity and age with acceptance of OCs is also related to the method preference of clients. Although younger and lower parity women tended to prefer pills while older and higher parity women usually preferred injectables, client preferences may have been influenced by prior conversations with clinic staff.

TABLE 4. Percentage of New Clients Who Were Given Pelvic Exams

	PELVIC EXAMS			NUMBER OF NEW CLIENTS
	Yes (%)	No (%)	Total (%)	
BASELINE	72.4	27.6	100.0	116
FOLLOW-UP	51.6	48.4	100.0	124

Table 4 shows that pelvic exams performed on new clients declined by over 20 percentage points between the baseline and follow-up surveys and that this change was significant ($p = .0001$). While the likelihood of having a pelvic exam declined, additional analyses indicated that the change did not lead to an increase in access to contraception. In order to understand why access did not increase, we need to understand the rationale for performing pelvic exams; this issue is explored in the next section.

F. Barriers Previously Unidentified

1. Oral contraceptives denied to women not menstruating during consultation

During the course of the analysis, it became apparent that some clients did not receive methods because of a barrier that had not been identified as important in Cameroon. This barrier was the requirement that a woman be menstruating before receiving pills to ensure that she is not pregnant. Pills can be provided at any time to non-contraindicated women, provided they are counselled to begin the first cycle within seven days after the first day of menstruation (Technical Guidance Working Group, 1994). Even if pills are taken during pregnancy, current data indicate that OCs do not put unborn children at significant risk of birth defects (Hatcher, 1994; American College of Obstetricians and Gynecologists, 1993; Simpson, 1990). Providers, who wish to be reasonably sure that a client is not pregnant, should check for symptoms of pregnancy, which include nausea, fatigue, breast tenderness, etc. (Technical Guidance Working Group, 1994).

Table 5 shows the percentage of new clients who received a pelvic exam according to the menstruation status of women in both the baseline and follow-up surveys. Only non-breastfeeding women were included in this analysis as some breastfeeding women should not receive combined pills. In both surveys, menstruating women were far more likely to have a pelvic exam than were non-menstruating women ($p < .05$ in both surveys). However, while pelvic exams decreased among non-menstruating women ($p = .06$), there was no significant decrease among menstruating women ($p = .17$).

TABLE 5. Percent of New Clients Who Had a Pelvic Exam by Menstruation Status

	PELVIC EXAM (%)	NUMBER OF NEW CLIENTS
BASELINE		
MENSTRUATING	80.4	46
NON-MENSTRUATING	52.6	19
TOTAL	72.3	65
FOLLOW-UP		
MENSTRUATING	76.6	55
NON-MENSTRUATING	40.0	28
TOTAL	60.2	83

* Table excludes breastfeeding women

When asked to explain why they perform pelvic exams, most providers said they check for genital infections and tumors (Appendix A, Table 6). However, if the purpose of a pelvic exam is to determine whether a woman has a sexually transmitted disease (STD) or some other infection, then it would be expected that most of these exams would be performed among non-menstruating women. However, this was not the case. It appears that the major purpose of a pelvic exam (see below) is to confirm that a woman who reports that she is menstruating is telling the truth and therefore can be provided with pills.

Table 6 shows that menstruating women in both the baseline and follow-up surveys were more likely to obtain OCs than were non-menstruating women ($p < .002$ in both surveys). In the follow-up survey, the total percentage of women who received OCs was lower because of stock-outs, but the difference in pill provision between menstruating and non-menstruating women was still large.²

² Because of small cell sizes we were unable to analyze the impact of both menstruation status and pelvic exams on pill provision. However, pill provision was highest among women who were menstruating and had pelvic exams (78 percent in the baseline survey and 62 percent in the follow-up survey)

TABLE 6 Percent of New Clients Receiving Pills by Menstruation Status

METHOD PROVIDED	MENSTRUATING	NON-MENSTRUATING
BASELINE		
Pills (%)	72.3	19.0
Number of New Clients	47	21
FOLLOW-UP		
Pills (%)	56.4	20.7
Number of New Clients	55	29

Women apparently knew that they were unlikely to get a method if they were not menstruating. A disproportionately greater number of women who attended family planning clinics were menstruating (65 percent in the baseline and 58 percent in the follow-up) than would be expected among a random sample of the general population of women of reproductive age (about 18 percent). (Hatcher, 1994)

Why are providers so concerned about menstruation? In the provider interviews, 21 of 22 respondents stated that clients must be menstruating before receiving combined pills (Appendix A, Table 7). Almost all said that they wanted to be certain that their clients were not pregnant. Many providers feared the effect that hormonal methods would have on pregnant clients. Others were concerned with preserving the reputation of hormonal methods and said that they avoid prescribing a method to a client who may be unknowingly pregnant and who will blame the pregnancy on method failure.

G. Barriers Whose Existence Could Not Be Determined

1. Family planning methods restricted to unmarried young women

Whether or not unmarried young women (clients under 19 years old) were restricted access to family planning could not be determined. In the baseline survey, only 12.1 percent of the new clients who attended family planning clinics were unmarried young women compared to 3.2 percent in the follow-up survey. Therefore, the number of unmarried young women surveyed was too low to determine if these women were denied access to hormonal methods. For this reason, we broadened the analysis to include all young women. The percentages increased slightly (to 13.8 percent in the baseline and 4.8 percent in the follow-up), but the number of women eligible for analysis was still too small to evaluate provider bias.

An issue that could not be addressed by this study is whether young women were discouraged from going to clinics because they had heard that the clinic staff were "biased" against them or because they were not interested in using family planning.

IV. DISCUSSION

Some barriers that were assessed had either a minor impact on contraceptive access (unnecessary lab tests and proof of spousal consent) or had an impact that could not be determined (adolescent restrictions). Further evaluation is needed to determine why so few young women seek family planning. A community-based survey of young women would provide information on why they do not go to clinics. In addition, in-depth provider interviews and observational studies using mystery clients would provide complementary information on how providers treat adolescent clients.

Changes in some barriers were difficult to evaluate because method stockouts during the follow-up survey disrupted method distribution patterns. Baseline data show that a small percentage of low parity women were likely to receive injectables and that a small percentage of older women were likely to receive pills. However, whether these method distribution patterns changed could not be determined because of method stockout problems during the follow-up data collection period. Other results indicate that provider attitudes regarding the provision of injectables did not improve, while attitudes toward maximum age on pill provision were modified but not eliminated.

One barrier that was reduced was the restriction on the number of OC cycles distributed to new clients. The number of OC cycles provided per new client increased after the dissemination of the guidelines. However, it is not clear why the barrier was reduced for new clients and not for revisiting clients.

One possible explanation for the apparent failure to provide revisiting clients with six or more OC cycles is that women may have been unaware that they could buy more than three cycles and simply did not bring enough money to purchase more pills. Since the follow-up client interviews were conducted less than three months (or three OC cycles) after the dissemination seminars, revisiting clients would not have been aware of the new pill distribution policy. A review of a sample of clinic daily registers dated after July, 1994 is needed to determine if OC cycle distribution increased.

A more likely explanation for the failure is that many providers believe that six months is too long for women to be away from the clinic. Providers are concerned that clients may experience medical problems that would remain undiagnosed if they were not required to return frequently. This belief indicates that providers do not trust women to recognize problems themselves and to seek care when they arise.

Lack of trust may have been a major reason behind the most significant medical barrier measured in this study: the requirements that OC clients be menstruating and have pelvic exams before receiving pills. The strong association between menstruation and pelvic exams suggests that there exists a two-step process that clients must complete: 1) they must tell their providers whether or not they are menstruating, and 2) if they are, then they receive pelvic exams to verify that they are telling the truth. Like many of the medical barriers identified in this report, this barrier exists because providers are concerned about clients' health.

There are a number of reasons that the guidelines were not more successful in changing provider practices; these reasons are as follows:

1. The documents are not specific enough in addressing eligibility criteria. For example, the Policy and Standards document says that all women of reproductive age should have access to pills, and all women (except adolescents) should have access to injectables. However, the documents do not specifically say that providers should not use age and parity criteria to prescribe particular methods. Moreover, the guidelines do not discuss the rationale for not using age and parity criteria for prescribing methods nor are there examples to underscore the point that providers should not use age and parity criteria to encourage women to use particular methods.
2. The documents provide guidance as to when certain exams and tests should be conducted. However, there is no statement that such tests and exams should be the exception rather than the rule. Moreover, as with eligibility criteria, there is no attempt to present examples to make clear that these process hurdles should be used rarely and not regularly.
3. The material referring to eligibility criteria and process hurdles is difficult to find; there is no place in either document where this information is summarized including the rationale for not requiring either the eligibility criteria or the tests and exams. Consequently, it may be difficult for the provider to appreciate the importance of changing practices relating to these barriers.
4. Finally, the dissemination seminars were not designed to reinforce the material on barriers. They emphasized the main material in the guidelines, namely, how to provide methods, what to do on particular visits, and how to deal with contraindications and side effects. The case studies also followed the didactic material.

Our findings show the need to give more attention to eligibility criteria and process hurdles in writing service delivery guidelines and in disseminating those guidelines. We hope that such attention will be more effective in changing practices and therefore increasing access to family planning.

V. APPENDIX - Results of Service Provider Interviews

A. Introduction

Interviews were conducted with thirteen service providers who attended dissemination seminars of the MCH/FP guidelines. Nine providers, who claimed that they did not attend the INTRAH regional dissemination workshops, were also interviewed, but these data are not included in the analysis. Nonetheless, it should be noted that, generally, responses from this group of providers were similar to those from the group which attended the regional dissemination seminars.

Each provider was asked to respond to a series of questions relating to material covered in the dissemination seminars.

Results from the provider interviews include information on the following medical barriers:

- OC cycle distribution
- Spousal consent requirements
- Laboratory examinations and clinical procedures
- Parity requirements
- Minimum and maximum age limits
- Weight requirements
- Pelvic exams
- Menstruation requirements

B. RESULTS

1. OC Cycle Distribution

Providers were asked how many OC cycles they distributed to new clients, and to revisiting clients seeking resupply.

TABLE 1a. The Number of Cycles of OCs Providers Claim to Provide to New Clients

NUMBER OF OC CYCLES PROVIDED	PROVIDERS NOT ATTENDING SEMINAR	PROVIDERS ATTENDING SEMINAR
One	3	3
Two	0	0
Three	6	9
Four	0	1
TOTAL	9	13
Mean	2.33	2.62

TABLE 1b. The Number of Cycles of OCs Providers Claim to Provide to Revisiting Clients

NUMBER OF OC CYCLES PROVIDED	PROVIDERS NOT ATTENDING SEMINAR	PROVIDERS ATTENDING SEMINAR
One	0	0
Two	0	0
Three	7	5
Four	0	0
Five	1	1
Six	1	4
Seven	0	3
TOTAL	9	13
Mean	3.56	5.00

Common reasons given by those providers who distribute less than six cycles per visit:

- "If I give her more and she has problems she won't return."
- "Regular check-ups are necessary. I'd give them more if they lived far away."
- "Women do not have enough money to pay for six cycles."
- "We need follow-up to eliminate contraindication and to ensure correct use."

2. Spousal Consent

Providers were asked if they require proof of spousal consent before providing reversible contraceptive methods.

TABLE 2. Spousal Consent Requirements by Method

SPOUSAL CONSENT REQUIRED	METHODS			
	PILLS AND INJECTABLES		IUDS	
	Providers not attending seminars	Providers attending seminars	Providers not attending seminars	Providers attending seminars
YES	0	1	2	2
NO	9	12	7	11
TOTAL	9	13	9	13

3. Laboratory Examinations and Clinical Procedures

Providers were asked to state which of the following examinations or procedures they routinely required before clients are allowed to begin using the following methods?

TABLE 3a. Examinations or Procedures Required for New Clients by Method

EXAMINATION OR PROCEDURE ROUTINELY REQUIRED	PILLS AND INJECTABLES		IUDS	
	Providers not attending seminars	Providers attending seminars	Providers not attending seminars	Providers attending seminars
PHYSICAL EXAMINATION (excluding pelvic)	Yes - 9	Yes - 13	Yes - 9	Yes - 13
WEIGHT MEASUREMENT	Yes - 9	Yes - 13	Yes - 9	Yes - 13
BLOOD PRESSURE	Yes - 9	Yes - 13	Yes - 9	Yes - 13
BLOOD TESTS	No - 9	No - 13	No - 9	No - 13
URINE TESTS	No - 9	No - 13	No - 9	No - 13
STD TESTS	No - 9	Yes - 1 No - 12	No - 9	Yes - 1 No - 12
PAP SMEAR	No - 9	No - 13	No - 9	No - 13

Providers were asked to state which of the following examinations or procedures they routinely required for revisiting clients who are using the following methods?

TABLE 3b. Examinations or Procedures Required for Revisiting Clients by Method

EXAMINATION OR PROCEDURE ROUTINELY REQUIRED	PILLS AND INJECTABLES		IUDS	
	Providers not attending seminars	Providers attending seminars	Providers not attending seminars	Providers attending seminars
PHYSICAL EXAMINATION (excluding pelvic)	Yes - 1 No - 8	Yes - 3 No - 9	No - 9	Yes - 3 No - 9
WEIGHT MEASUREMENT	Yes - 9	Yes - 12	Yes - 9	Yes - 12
BLOOD PRESSURE	Yes - 9	Yes - 12	Yes - 9	Yes - 12
BLOOD TESTS	No - 9	No - 12	No - 9	No - 12
URINE TESTS	No - 9	No - 12	No - 9	No - 12
STD TESTS	No - 9	Yes - 1 No - 11	No - 9	Yes - 1 No - 11
PAP SMEAR	No - 9	No - 12	No - 9	No - 12

4. Parity

Providers were asked to state their parity limits for family planning acceptors by method.

TABLE 4. Parity Requirements by Providers for Each Method

NUMBER OF CHILDREN REQUIRED	METHODS			
	COMBINED PILLS		INJECTABLES	
	Providers not attending seminars	Providers attending seminars	Providers not attending seminars	Providers attending seminars
None	5	8	0	3
One	3	5	4	4
Two	1	0	2	0
Three or more	0	0	3	6
TOTAL	9	13	9	13

Listed below are providers' reasons for parity requirements:

a. Minimum number of children:

- "If she uses a FP method and cannot get pregnant later, she will blame family planning."
- "Injectable is not as easily reversible as the pill."
- "Makes placing IUD easier."

5. Pelvic Examinations

Providers were asked if they performed pelvic exams before prescribing hormonal methods.

TABLE 5a. Pelvic Exams Performed on New Clients According to Providers

METHOD	PELVIC EXAMINATION	
	Providers not attending seminars	Providers attending seminars
PROGESTERONE ONLY PILL	Yes - 9	Yes - 13
COMBINED PILLS	Yes - 9	Yes - 13
INJECTABLES	Yes - 9	Yes - 13
IUDS	Yes - 9	Yes - 13

Listed below are reasons for performing pelvic exams on new clients offered by providers:

a. Hormonal methods:

- "No cancer."
- "Check for infections."
- "No uterine growths."
- "Genital infections."
- "Excessive bleeding."
- "Check for goiter, spleen/liver problems."

b. IUD:

- "Make sure cervix is clean and without infection, PID."
- "Make sure there is no pregnancy."

TABLE 5b. Pelvic Exams Performed on Revisiting Clients According to Providers

METHOD	PELVIC EXAMINATION	
	Providers not attending seminars	Providers attending seminars
PROGESTERONE ONLY PILL	Yes - 2 No - 7	Yes - 3 No - 9
COMBINED PILLS	Yes - 2 No - 7	Yes - 3 No - 9
INJECTABLES	Yes - 2 No - 7	Yes - 3 No - 9
IUDS	Yes - 7 No - 2	Yes - 7 No - 5

6. Menstruation

Providers were asked if they require that their clients be menstruating before they receive hormonal methods or IUDs.

TABLE 7. Menstruation Required by Method

MENSTRUATION REQUIRED	METHODS			
	PROGESTERONE- ONLY PILLS		COMBINED PILLS	
	Providers not attending seminars	Providers attending seminars	Providers not attending seminars	Providers attending seminars
YES	7	11	9	12
NO	2	2	0	1
TOTAL	9	13	9	13

Listed below are some common reasons offered by providers on why they require that clients be menstruating:

- "To make sure she is not pregnant."
- "If you give her a method while she is pregnant, she will think that family planning is not effective."
- "Cuts down on costly pregnancy tests."
- "Must always start pills at beginning of ovulation"
- "You cannot add hormones to hormones."
- "No pregnancy - must be sure that uterus is free. Some ladies tell lies."

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