



Barriers to Access and Quality

MAQ Exchange

3-1

Often women and men who seek family planning and reproductive care face difficulties in gaining access to quality services. In this module, we will discuss the kinds of difficulties clients face and what programs can do to minimize these and assure quality.

Special Note on Gender: Gender is an important cross-cutting issue throughout the module. Because gender refers to the socially and culturally constructed roles and power dynamics between women and men, as both client and provider, it is an integral issue that cuts across many reproductive health service delivery systems and affects both sides of supply and demand. The barriers that will be identified in this module have a gender dimension, which is why gender is such a critical issue to address in any effort to improve access and quality.

Because gender issues are part of the country context, it is important for the participants to keep gender at the forefront of their minds as they take part in the MAQ Exchange activity. Participants may want, at the start, to define what gender means to them and how it affects the work they do. Let them know that this idea will be expanded upon later in this particular module, also.



Objective

To discuss

- ◆ **Barriers that affect and limit access to quality family planning**
- ◆ **Strategies for improving client access to quality family planning**

Access Barriers

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We will discuss practical ways that programs can improve client access to quality family planning care.



120 Million Women Report Unmet Need for Contraception Worldwide

- ◆ What are the principal reasons for this unmet need?
- ◆ Which reasons are of greatest concern?
- ◆ Which reasons have the greatest impact?
- ◆ Are there specific gender issues that contribute to this unmet need?
- ◆ What access barriers exist in your country?
- ◆ Which barriers are of greatest concern to you?
- ◆ What interventions would you suggest?

Source: Robey et al, 1992; World Bank, 1993.

Access Barriers

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One hundred and twenty million women need or want contraception but are not currently using a contraceptive method. Let's look at the reasons for this unmet need, the most important barriers in [insert name of country or area] and how these barriers might be overcome.



Access Barriers

Barriers to effective family planning services

Physical		Medical
	Location	
Cost		Knowledge
Inappropriate eligibility criteria		Process
		Gender
Regulatory		
	Socio-cultural	
Time		norms
	Legal	Provider
Poor CPI		bias

Outcomes when barriers are overcome

- ➔ Access to services
- ➔ Contraceptive choice
- ➔ Quality services provided

Access Barriers

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When barriers exist, clients, even motivated clients, may feel as though they have encountered a brick wall that keeps them from obtaining quality services and/or their choice of method. Barriers are an important cause of the unmet need for family planning.



Physical and Time Barriers: Getting Services

- ◆ Range of services/choices
- ◆ Reasonable waiting time
- ◆ Appropriate provider available
- ◆ Freedom from physical obstacles
- ◆ Client needs and preferences met

Access Barriers

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Now we'll look at specific barriers to services. Often, the first barriers that clients encounter are difficulties in getting to services and getting there when they are available. This slide lists a few of those barriers, some of which also have distinct gender dimensions. Barriers often impact women more intensely because they are the ones most often responsible for children. In addition, women may work outside the home. Clinics, however, may not take into account that women's time is valuable-- because of parental or work responsibilities--and ask her to wait an unreasonable amount of time. If the client is unable to find childcare for her children or cannot be away from her work for several hours, she may not be able to obtain the services she needs.



Location Barriers

- ◆ Distance, travel time, poor roads
- ◆ Public transportation
- ◆ Easy to find
- ◆ Convenient hours
- ◆ Anonymity



Access Barriers

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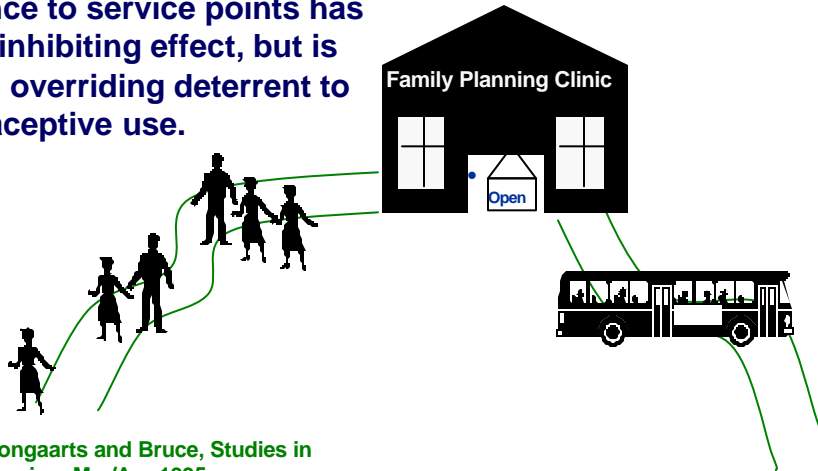
The location or placement of the service delivery point is important. Here are some of the factors to consider.

Again, location barriers are often directly related to gender and are especially a problem for women. Because of women's low economic status, they may not have adequate resources to use public transportation, or they may be unable to get to a clinic because it is too far away. In some cultures, women also must be accompanied by a man when out in public. In addition, sometimes clinic hours are not convenient for women given their childcare and economic responsibilities. However, some of the burden of childcare could be alleviated if the clinic is able to provide a child-friendly facility and perhaps even childcare on site. Anonymity also may be difficult, because often women cannot make family planning decisions on their own.



Distance Barriers

Distance to service points has some inhibiting effect, but is not an overriding deterrent to contraceptive use.



Source: Bongaarts and Bruce, *Studies in Family Planning*, Mar/Apr 1995.

Access Barriers

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Although the distance a client must travel can be a barrier, and it may require more money for passages of client and children, often these are not serious deterrents. In fact, sometimes clients will choose to travel a greater distance in order to obtain services they want. In certain instances, for example, a woman may travel farther to get services because she fears being identified by community members at the family planning clinic, or a man may travel farther for fear of being ridiculed by relatives, friends, neighbors, or community members for seeking contraception. Of course, this also says something about the confidentiality and anonymity of services in clinics that may be closer to the client's home.

Let's look at some data on this.



Clients Do Not Always Use Closest Service Delivery Point

Country	% of clients not using closest FP site	Reason
Nigeria	39	▪ Better services were available elsewhere
Peru	24	▪ Better services were available elsewhere
Ghana	51	▪ Better services could be obtained elsewhere ▪ Wider range of services could be found elsewhere

Source: Bongaarts and Bruce, Studies in Family Planning, Mar/Apr 1995.

Access Barriers

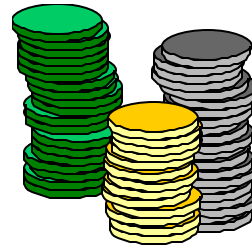
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Here are examples of times when clients specifically said they did not go to the closest service delivery point, but rather to one where they could get specific services they wanted.



Cost Barriers

- ◆ Price of contraceptive method
- ◆ Hidden fees
- ◆ Cost of transportation
- ◆ Opportunity costs
- ◆ Hidden costs
(time, childcare, etc.)



Many people will pay modest fees for RH services.

Access Barriers

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Although many clients are willing to pay something for reproductive health services, cost can be a barrier to obtaining services. Programs should be aware of fees imposed for the method and for services as well as other costs to the client, such as transportation, childcare and loss of pay when away from their job. Programs also may want to incorporate sliding scale fees utilizing socioeconomic impact assessments.

The facilitator may want to explore how gender issues are related to cost barriers. To begin this discussion, the facilitator should use the following quote from one of the participants of a study in Brazil:

“We didn’t take care in the right way; because to go to the health post is so far, we don’t have the money to go; women cannot have time to go.”

Ask the participants to discuss why women lack resources, why they lack control over how money is spent, and how this affects their ability to obtain quality family planning and reproductive health services. The participants also could discuss in more detail the hidden costs of obtaining health services.



Knowledge Barriers

Country	% of Women with Unmet Need Reporting Lack of Knowledge as Principal Reason for Nonuse
Kenya	27.6
Uganda	48.2
Sri Lanka	10.4
Thailand	4.4
Bolivia	52.8
Ecuador	5.6
Peru	17.4

Source: Bongaarts and Bruce, *Studies in Family Planning*, Mar/Apr 1995.

Access Barriers

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Lack of knowledge about contraceptive methods is also an impediment to getting contraception. Note that approximately half of the women with unmet needs in Uganda and Bolivia say that lack of knowledge has kept them from using contraception.

Also: Ask the participants to share any data or information they might have about their country regarding lack of knowledge as a reason for unmet need for both women and men.



Medical Barriers

- ◆ Inappropriate “contraindications”
- ◆ Process hurdles (The “Obstacle Course”)
- ◆ Other eligibility criteria -- age, parity, marital status, etc.
- ◆ Which provider can provide services and whether the provider is male or female
- ◆ Provider bias
- ◆ Regulatory barriers
- ◆ Lack of equipment (sterilization)
- ◆ Where services can be provided
- ◆ Inappropriate follow-up (e.g., side effects management)

Access Barriers

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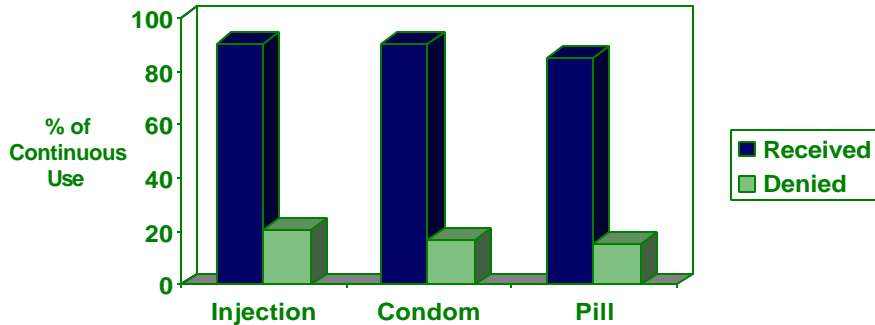
Medical barriers, or unnecessary limitations placed upon the delivery of contraceptive services by the medical establishment and/or service delivery guidelines, often keep clients from accessing services they need and want.

Now let's look at some of these medical barriers.



Receiving Contraceptive of Choice Increases Continuous Use

Indonesia



Source: Pariani, Studies in Family Planning, Nov/Dec 1991.

Access Barriers

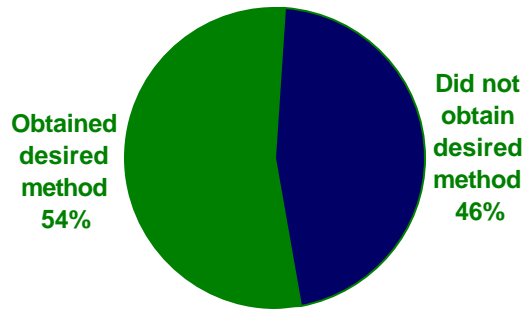
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Clients who receive their choice of contraceptive method are much more likely to continue using this method. This Indonesia study shows that women who receive their contraceptive choice are much more likely to continue using this method than women who do not receive their method of first choice.



Clients Often Do Not Receive Their Desired Method

Of Clients Who Indicated a Preferred Method:



Source: Nigeria: The Family Planning Situation Analysis Study, Population Council, 1992.

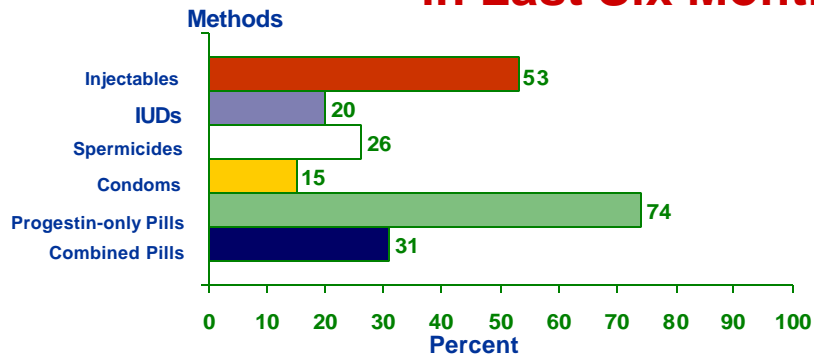
Access Barriers

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Even though we know that providing what the client wants is important, often clients do not receive their choice of contraceptive method. This Nigeria study found that almost half the clients did not receive their method of choice.



Percentage of Points Providing a Method Having a Stockout in Last Six Months



Source: Nigeria: The Family Planning Situation Analysis Study, Population Council. 1992.

Access Barriers

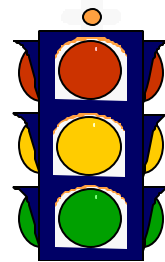
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Sometimes, although providers want to provide the method wanted by the client, they do not have that method available. Note how often clinics in Nigeria did not have specific methods available during just one six-month period. Thus, we see that logistics play an important role in keeping clients from receiving their method of choice.



Major Eligibility Restrictions

- ◆ Age
- ◆ Parity
- ◆ Marital status
- ◆ Parental or spousal approval



Access Barriers

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Rules or practices about who can receive certain contraceptive methods also pose a barrier to client choice of method. For example, some providers may refuse to provide hormonal contraceptives to women who do not have several children. Or they may require the husband's approval before an IUD can be inserted.

Eligibility rules and practices are also commonly shaped by gender norms. And, these rules and practices can reinforce gender norms, which often prevent women from exercising their choices about sex, pregnancy and methods.



Percentage of Providers Who Cite Eligibility Restrictions for FP Method

Variable	Pill	Condom	IUD	Injectable	Foam
Age limit	70.4	1.2	46.9	65.4	6.4
Number of live children	77.8	14.8	75.3	91.4	20.5
Approval of spouse	24.7	43.2	40.7	30.0	34.6
N	81	81	81	81	81

Source: Pakistan Situation Analysis, 1994.

Access Barriers

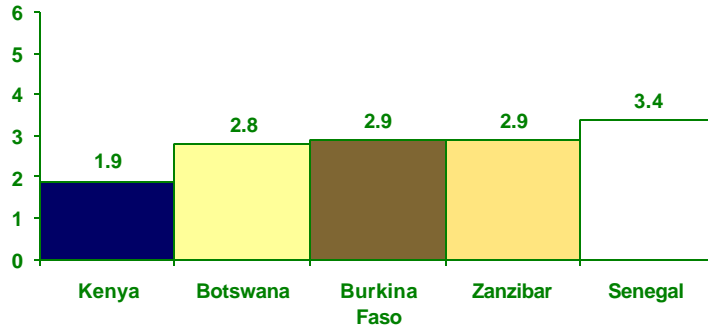
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In Pakistan, a 1994 Situation Analysis showed that over 70 percent of providers would not provide the pill to women who were too young or too old, and would not provide the pill, IUD or injectable to women who did not already have a certain number of live children.



Mean Parity Required Among Providers Who Report Restrictions Based on Parity

Injectables



Source: Population Council, 1998.

Access Barriers

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Note, although Senegalese providers report restrictions based on parity less often, those providers that do, require a mean parity of 3.4 children.



Process Barriers

- ◆ Unnecessary barriers to initiation (e.g., menstruation, STI)
- ◆ Rest periods required
- ◆ Unnecessary procedures required (e.g., pelvic exam, lab tests)
- ◆ Inappropriate follow-up schedule (e.g., IUD follow-up, only 1 pill cycle given)
- ◆ Inappropriate side effects management



Access Barriers

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Providers may also limit contraceptive use by requiring clients to take unnecessary steps (process hurdles) to use contraception. For example, they may require women to be menstruating, to rest from using a method, or have unnecessary exams or tests. They may also require women to come back to the clinic more often than necessary, or may manage side effects inappropriately. Additionally, providers might inappropriately limit contraceptive use based on the presence of an existing STI when this might not be medically contraindicated.



Providers Requiring/ Performing Pelvic Exam in Senegal



Source: Population Council, 1998.

Access Barriers

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Providers in Senegal were shown in this study to often require and perform pelvic exams for women who want to start pills or injectables, even though a pelvic exam provides no useful medical information related to the use of these methods. And although a pelvic exam is important for clients wishing to start using an IUD, only slightly more than 80% of the providers actually performed a pelvic exam for new IUD clients. So we can see that providers may be both overly cautious in requiring unnecessary tests, or may not require exams that are actually needed for safety.



Menstruating Requirement: A Major Barrier to OC Access

Country	Findings
Ghana	46% of providers give OCs only to menstruating women
Kenya	71% of providers give OCs only to menstruating women
Jamaica	82% of simulated clients required to be menstruating or have negative pregnancy test
Kenya	78% of non-menstruating clients (35% of all prospective new clients) sent home

Source: Stanback, 1999.

Access Barriers

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As we see on this slide, providers often require a woman to be menstruating in order to be sure that she is not pregnant, before being given a contraceptive method. This may well be one of the most significant barriers preventing women from getting the family planning services they seek. A recent FHI study in Kenya showed that 78% of non-menstruating clients, or 35% of all prospective new clients, were sent home without the method they wanted.



Barriers to Good CPI

- ◆ **Some providers do not realize value of good CPI for satisfaction and successful use**
- ◆ **Some providers not courteous, respectful, open and/or professional**
- ◆ **Questions not always encouraged**
- ◆ **Hierarchy and technicality of medical culture**
- ◆ **Problems related to age, race, class, gender and/or religious status**
- ◆ **Language and literacy can be barrier**
- ◆ **Power imbalance between client and provider**

Access Barriers


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Good client provider interaction (CPI) is closely linked with client satisfaction and successful contraceptive use. Providers may not be aware of this linkage. So, it is important that this information be given to providers.

Programs need to support providers who are working to create courteous, respectful, open and professional environments. Professional communications must be a priority. Both clients and providers should be encouraged to engage in good questioning and respective listening.

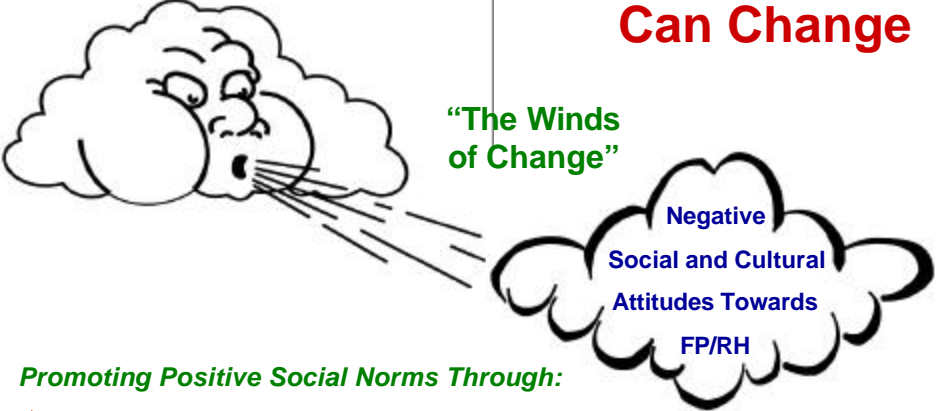
However, in many societies, women are not encouraged to speak out, ask questions and/or interact with strangers or those with higher education or status or men. This has a significant effect on how women clients interact with male doctors.

Clients also have a major role to play in improving CPI. Some behaviors that hamper access to quality family planning services are important to change.



Sociocultural Barriers Can Change

“The Winds
of Change”



**Negative
Social and Cultural
Attitudes Towards
FP/RH**

Promoting Positive Social Norms Through:

- ➔ Behavior change and communication
- ➔ Positive image of service delivery and contraception

Access Barriers

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Negative social and cultural attitudes about family planning and reproductive health, or misunderstandings about them, can also impede access to quality services. Examples of such attitudes include:

- Females should remain virgins until married, but males should experiment and “test” their sexuality/virility and have multiple partners.
- Married females should have children before they use contraception in order to prove their fertility.
- Gender-based violence (including female genital cutting) should be accepted.
- Family members (e.g., in-laws) should be involved in decision making.
- Use of contraception or provision of sexuality education will promote promiscuity.
- Men and boys do not need to have FP/RH services.
- Youth do not need special FP/RH services (e.g., clinic location, hours, cost, etc. do not need to accommodate youth).

Positive social norms, replacing outdated norms, can be created through behavior change and communication and through promotion of a positive image of family planning and contraception.



Gender Barriers

- ◆ **Women often lack power to make decisions regarding sex, pregnancy and method use**
- ◆ **Partners/couples do not always explicitly discuss family size or contraception**
- ◆ **Gender-based violence can impact service provision and method use (including FGC)**
- ◆ **Providers not always sensitive to power imbalances that exist within FP settings**
- ◆ **FP facilities not always accessible to men**
- ◆ **Men not encouraged to promote FP/RH**

Access Barriers

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Although most of you probably have a good understanding of what gender means, it is important to reiterate that gender refers to the culturally and socially defined aspects of being male or female. As such, barriers based on gender can also hamper access to quality family planning and reproductive health services. This slide lists some possible gender barriers.

Other important gender barriers include:

- Single women may be discriminated against in family planning settings.
- In many cultures, it is considered inappropriate to discuss sexual matters.
- Because women are often less educated or illiterate, their ability to access and obtain quality family planning and reproductive health services may be limited.
- Women are commonly unable to make family planning decisions on their own (often partner or family approval is needed).



Husband Disapproval Affects Contraceptive Use

“My husband and I never used any family planning method because my husband refused me permission to do so.”

-- Woman in Cebu, the Philippines

“If my wife makes the decision to use family planning without my consent, I would divorce her.”

-- Malian man

Access Barriers

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This slide shows us two examples of how the power and control of the husband can affect a woman's use of contraception.



Breaking Down Gender Barriers

- ◆ Reach women who cannot leave the home, do not have access to money or cannot be seen by male doctors
- ◆ Link FP/RH with other sectors to improve women's lives
- ◆ Promote gender-sensitive IEC strategies
- ◆ Maximize participation of women providers
- ◆ Offer couple counseling
- ◆ Encourage men (partners) to play a role in FP
- ◆ Address men's interests and concerns

Access Barriers

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Although it may seem difficult, country programs can take steps to reduce gender barriers. For example, they can improve the access of women to FP outside of clinics, have more female providers, link family planning to other sectors that work to improve women's lives (e.g., income generation or education/literacy projects) and proactively encourage male involvement and responsibility through couples counseling, men's groups at clinics and making clinics more friendly for men.

Barriers based on unequal power relations can also hamper access to quality family planning and reproductive health services. Thus, it is important to integrate a gender perspective into PHN programs. Ways to do this include:

- 1) take into consideration differences in *power* between women and men;
- 2) change the *power dynamics* between men and women (e.g., by training providers in good CPI);
- 3) involve men in reproductive health issues and programs (e.g., by encouraging them to take responsibility for their sexual actions);
- 4) understand the *cultural roles* of sexual and reproductive health behavior; and
- 5) give women a voice.

A good example of a project where gender barriers were broken down was a social marketing campaign in Tanzania (done by PSI) which promoted women initiating condom use. The poster portrayed a woman in a bar initiating condom use (not a common behavior), and translated as "Beware -- without Salama [condoms]? Never!" Specifically, the project addressed changing the power dynamics/imbances between women and men in that it empowered women to change their roles and improved female-male communication patterns and normative female-male interaction around sexuality.



Access Barriers for Adolescents

- ◆ Clinics not inviting to youth
- ◆ Providers reluctant to serve unmarried youth
- ◆ Laws/policies may prohibit provision to youth, especially unmarried youth
- ◆ Lack of transportation or money for services
- ◆ Limited or inconvenient clinic hours
- ◆ Fear of judgment or discovery
- ◆ Concern about pelvic exams and side effects
- ◆ Cultural biases against premarital sexual relations

Access Barriers

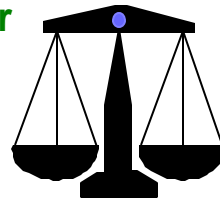
3-26

Adolescents as a group face considerable barriers to getting family planning and reproductive healthcare. In addition to the fact that many clinics and providers are not inviting to youth, even providers willing to serve youth may not be trained in sexuality. These factors can result in a lack of information and services needed by youth. Also, country laws and policies may result in barriers to service. Youth may also be unable or reluctant to get to service delivery points or to undergo a pelvic exam. All of these barriers result in adolescents not getting the family planning and reproductive services they need.



Legal and Regulatory Barriers

- ◆ Some safe methods may not be legal (approved)
- ◆ Inappropriate restrictions on who can provide
- ◆ Legal barriers to private sector provision or growth
- ◆ Import restrictions
- ◆ Customs duties and taxes



Access Barriers

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Laws and regulations may also restrict access to contraception. For example, countries may not legalize all available, safe contraceptive methods, or may place restrictions on who can provide certain services. Import restrictions and customs taxes can also limit contraceptive availability, giving clients fewer method choices. Providers also may not be aware of legal changes related to contraception or they may give inappropriate information.



Provider Bias

- ◆ **Often, well-intending providers think only they know best - so do not elicit client preferences**
- ◆ **Clients vary - most but not all have a strong preference**
- ◆ **Provider needs to consider client's specific situation and let client select method**
- ◆ **Programmatic pressures favoring certain methods (e.g., provider targets) may influence providers**

Access Barriers

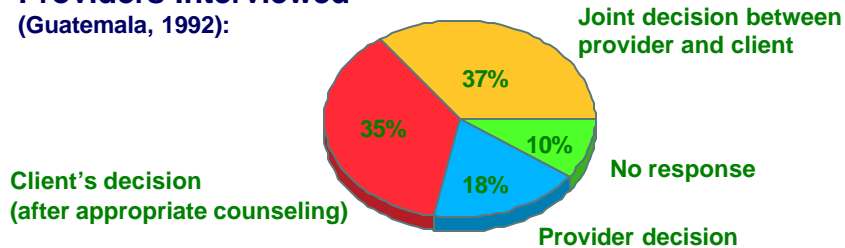
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As discussed earlier, clients should be given their choice of contraception if this method is safe for them and available. Often, however, providers do not listen to the client's preferences and make a different choice for the client, or insist upon explaining all methods in detail to the client, or pressure the client to accept a method that the provider prefers or that meets a program target rather than meets a client's expressed needs and wishes. Providers need to be careful not to bias a client's choice or make a choice for the client. They should also be aware of gender issues when providing information and seeking choices from clients (i.e., power imbalance between client and provider and the doctor's "god-like" status, etc.).



Who Should Decide Which Method is Most Appropriate?

Among Health Care Providers Interviewed (Guatemala, 1992):



Source: MOH Reproductive Health Unit in collaboration with The Futures Group, An Assessment of Medical Barriers to FP in Guatemala, 1992.

Access Barriers

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As this study from Guatemala shows, in almost one-fifth of the cases examined, the provider made the decision for the client, and in over a third of the cases it was a joint decision. It is preferable to have the clients themselves make the decision--after appropriate counseling.



How Do We Improve Access and Reduce Barriers?

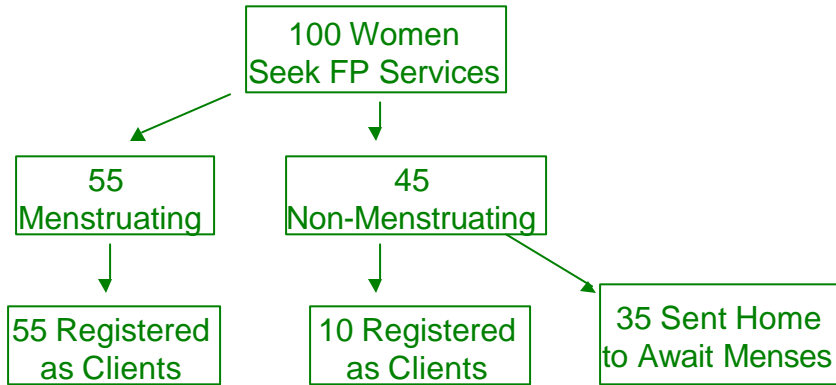
Access Barriers

3-30

Let's look at how programs might reduce some of the barriers to access to quality service that we've discussed.



Menstrual Requirement is a Major Access Barrier in Kenya



Source: Stanback, 1999.

Access Barriers

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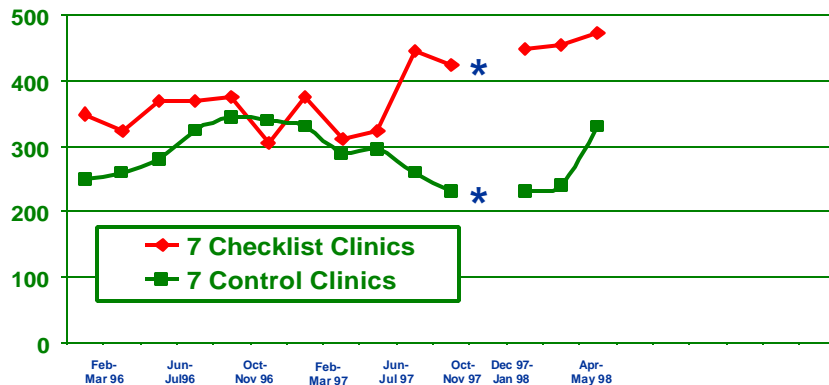
Making changes in menstrual requirements is an important means to increase access. As discussed earlier, requiring women to be menstruating when they receive contraception is a major access barrier for clients. A recent study in Kenya showed that 35% of potential clients were turned away due to providers' application of unnecessary menstrual requirements.

And the number of women not receiving contraception when needed may have been even higher, because some women probably did not even attempt to get services due to their knowledge of the menstrual requirement.



Checklists for Non-Menstruating Clients Can Improve Access

New Client Volume



*12/97 – 1/98 excluded due to national nurses' strike in Kenya

Access Barriers

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In an effort to see whether the menstruation requirement could be eliminated, an intervention using a provider checklist was carried out. The results of this intervention showed that when providers used a simple 6-item checklist to determine pregnancy a dramatic increase in new client volume occurred. Questions on the checklist include:

- 1) Have you given birth in the last 4 weeks?
- 2) Are you less than 6 months postpartum **and** fully breastfeeding **and** free from menstrual bleeding since you had your child?
- 3) Did your last menstrual period start within the past 7 days?
- 4) Have you had a miscarriage or abortion in the past 7 days?
- 5) Have you abstained from sexual intercourse since your last menses?
- 6) Have you been using a reliable contraceptive method consistently and correctly?

*If client answered "NO" to all questions, pregnancy cannot be ruled out and client should await menses or use pregnancy test.

*If answered "YES" to any one of the questions and is free of signs/symptoms of pregnancy, client should be provided with desired method.



Updating National Guidelines

Revising guidelines can reduce unnecessary barriers, increase the number of clients served and improve quality of care

Revising National Guidelines in Ghana contributed to:*

- ◆ **130% increase in injectable users**
- ◆ **99% increase in women choosing sterilization**

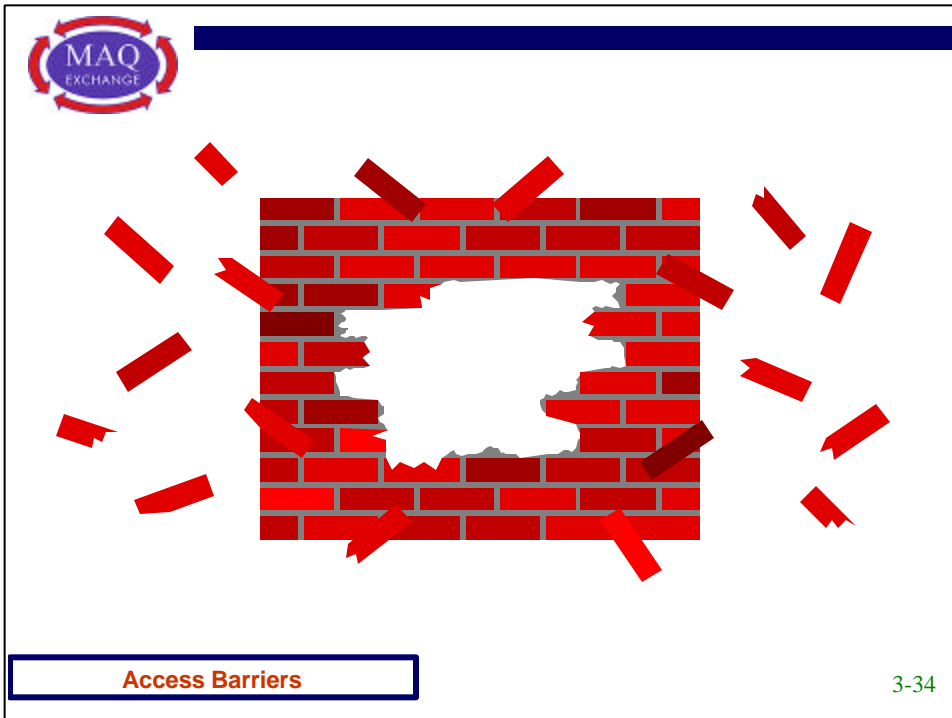
* Following a subsequent evaluation at two urban service sites.

Sources: INTRAH, Jan 1993 and
USAID, Monthly Activities Report, Jan/Feb 1997.

Access Barriers

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Barriers also can be reduced if a country goes through the process of educating managers and providers about the WHO and USAID best practices guidelines and then revises their own country guidelines and educates and trains providers in the new guidelines. As this study in Ghana shows, after guidelines were revised in that country a significant increase in injectables use and female sterilization occurred.



When barriers are eliminated or reduced, clients have significantly greater access to quality reproductive health services. Reducing barriers breaks down the wall between client needs/wishes and services provided.



OPTIONAL SLIDES

3-35



Providers Often Inappropriately Restrict Use of Methods

Percentage of Providers Who Restrict Use of Methods			
Reasons	Oral Pill	IUD	Injectable
Blood pressure	90.1	4.0	89.8 *
Diabetic	50.6	4.0	50.6
Irregular/heavy bleeding	23.4 *	55.0	7.5
Jaundice/anemia	93.8	8.0	74.6
Swelling	2.5	8.1	-
Headache	11.1	-	16.3
Tuberculosis	-	2.7	11.3 *
Pelvic Infection	-	29.7 *	-

Source: Pakistan Situation Analysis, 1994.

* Especially inappropriate.

Access Barriers

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As this slide from the 1994 Pakistan Situation Analysis shows, providers also unnecessarily restrict use of methods based on other medical conditions that are unrelated to contraceptive use. For example, providers may refuse the pill to women who have heavy or irregular bleeding, when pill use might actually help regularize bleeding for these women. They also may refuse injectables to women who have high blood pressure or tuberculosis, even though there is no danger for these women in using injectables. Providers may also refuse an IUD to women who have had a past pelvic infection.

It is important to point out, however, that some of the restrictions listed may actually be appropriate reasons for restricting certain methods depending on their severity.



Medical barriers are “...practices derived at least partly from a medical rationale, that result in a scientifically unjustifiable impediment to, or denial of, contraception.” These include eligibility restrictions, process barriers, contraindications and provider limitations/bias.

Shelton, Angle, Jacobstein, *The Lancet*,
Volume 340, November 28, 1992.

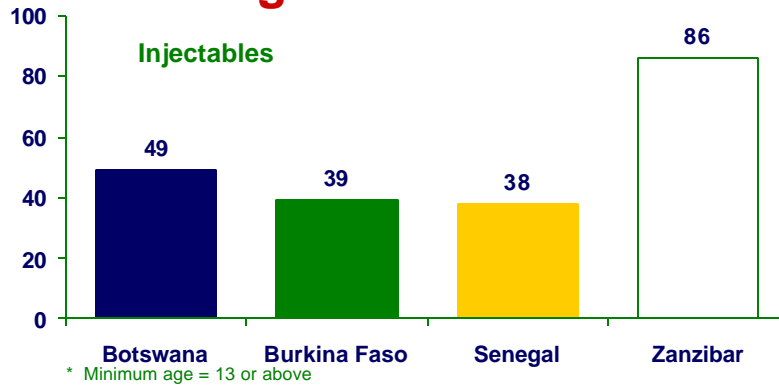
Access Barriers

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Medical barriers are a significant impediment to clients getting the reproductive health services desired and in helping clients reach their reproductive health goals.



Percentage of Providers Who Restrict Methods Based on *Minimum Age** in 4 African Studies



Source: Population Council, 1998.

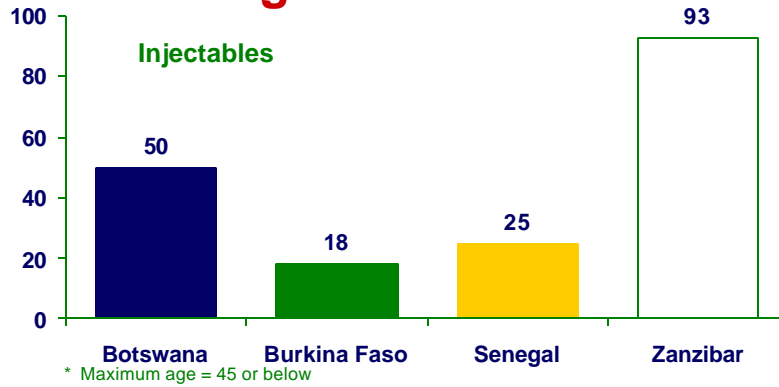
Access Barriers

3-38

The requirement that clients be a certain age in order to receive contraception also keeps clients from getting services desired. In four African studies, for example, a significant number of providers will not provide contraception to clients under 13 years of age. This age restriction puts sexually active adolescents at risk of pregnancy and STDs/HIV, even when they are making the effort to try to protect themselves.



Percentage of Providers Who Restrict Methods Based on Maximum Age* in 4 African Studies



Source: Population Council, 1998.

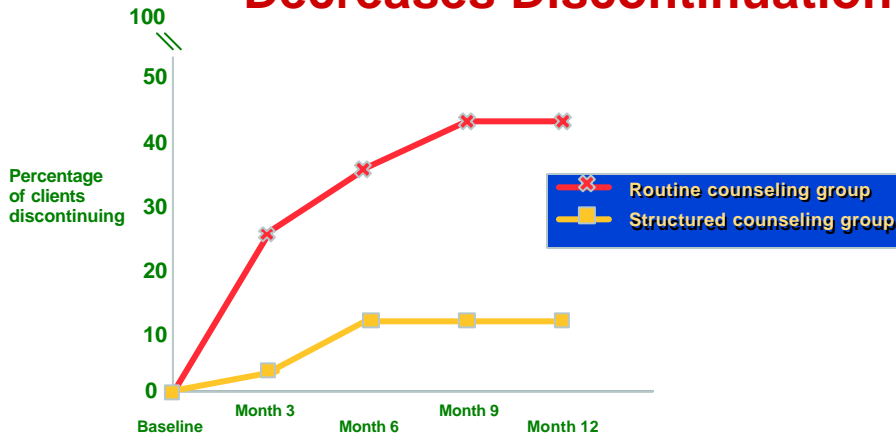
Access Barriers

3-39

Providers may also refuse contraception to women who are over a certain age, even though they may well be at risk for pregnancy. As this slide shows, more than 90% of providers refuse injectables to women over age 45 in Zanzibar and 50% of providers refuse injectables to women over age 45 in Botswana.



Counseling About Side Effects Decreases Discontinuation



Source: Zhen-Wu Lei et al, Contraception, Vol 53, 1996.

Access Barriers

3-40

Providers may neglect to talk with women about side effects, thinking that this may discourage women from using a method. Unfortunately, when women are not told about side effects ahead of time, and are not counseled on how to deal with them, they are more likely to discontinue a method when they experience side effects. This study in China clearly shows that women in a counseling group that was specifically structured to discuss side effects were considerably less likely to discontinue their method than women given routine counseling that did not thoroughly discuss side effects. Counseling about side effects also increases clients' trust in services.



Clinic Organization Barriers Santa Barbara, Brazil

- ◆ **Four-hour session** → **< two hours**
- ◆ **Pregnant women first priority**
- ◆ **Physicians doing routine functions**
- ◆ **Complex appointment scheduling**
 - **Only taken on certain days**
 - **Up to 1-2 months in advance**
 - **Hours of waiting time**
- ◆ **Waiting time for consultation: 2.5 - 4 hours**

Source: Diaz M et al, Studies in Family Planning, March 1999.

Access Barriers

3-41

Taken from a participatory action research project in southern Brazil, this slide shows some of the major constraints in availability of and access to family planning and reproductive health services for women, as well as deficiencies in quality of care.

Interventions designed to address these weaknesses focused on training, restructuring providers' roles and service delivery patterns, the management process, the creation of a referral center, and the introduction of injectables, vasectomy services and a program for adolescents.



“I go there at three in the morning, and at seven my wife comes and she stays in line and I go to work.”

Getting an appointment “is like winning the lottery.”

**-- Focus Group Interviews
Santa Barbara, Brazil**

Source: Diaz M et al, Studies in Family Planning, March 1999.

Access Barriers

3-42



Access Issues in Malawi (Mystery Client Study)

- ◆ Percentage of clients turned away ??

34%

- ◆ Average waiting time ??

2 hours, 22 minutes



Access Barriers

3-43

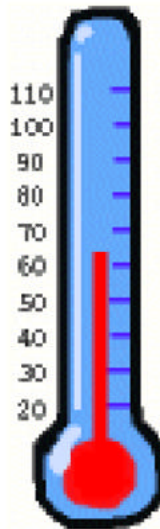


Reasons Clients Turned Away (Malawi Mystery Client Study)

- ◆ Lack of supplies/equipment
- ◆ Staff away or too busy
- ◆ Scheduling (stated: wrong day, date, time, etc.)
- ◆ Judged “suitability” - not menstruating, HBP, STD, adolescent, pregnant, etc.
- ◆ Provider bias (e.g., judged need, unmarried)
- ◆ Provider needs (e.g., grief, tired, garden work)

Access Barriers

3-44



How hot is hot?

Temperature is a continuum.

Access is too.

Access Barriers

3-45