Do Family Planning Service Providers in Tanzania Unnecessarily Restrict Access to Contraceptive Methods?

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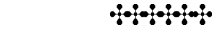

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Abstract

Context: Medical barriers can limit the use of family planning services, even in situations where family planning services are physically accessible and economic barriers are few. This study investigates the presence of four types of medical barriers among providers at government family planning service delivery points in Tanzania: overspecialization, eligibility restrictions, process hurdles, and provider bias.

Methods: Data from the 1996 Tanzania Service Availability Survey are used in the study. Barriers are analyzed by type of provider, type of facility, and urban/rural location. Estimates of the proportion of facilities that are "barrier-free" are also made.

Results: A relatively high proportion of provider's restrict eligibility by age, particularly for oral contraceptives, the most widely used method by Tanzanian women. Restrictions were also observed according to a woman's marital status, parity, and spousal consent. Medical aides, trained midwives, MCH aides, and auxiliary staff, the most common type of family planning service provider in rural areas, were the most likely to impose age restrictions (79 to 81 percent) for the pill. Ten to 13 percent of providers reported that there was at least one modern method that they would never recommend, and 40 percent reported inappropriate process hurdles in the provision of hormonal methods. In the aggregate, these restrictions and hurdles severely limit access to contraceptives for certain groups of women. Young, unmarried, non-menstruating women, for example, would encounter one or more barriers or process hurdles at more than 70 percent of urban and 80 percent of rural facilities.

Conclusions: Although the Tanzanian National Family Planning Program has made considerable progress in improving access to family planning services in the 1990s, further efforts are needed to reduce and ultimately eliminate unnecessary provider restrictions to contraceptive use. Compliance with the National Family Planning Program's service guidelines and standards would seem to be in need of greater emphasis in pre- and in-service training and during supervisory visits.

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Introduction

At the beginning of the decade, Tanzanian women faced few obstacles with regard to physical access to facilities authorized to offer family planning services. Estimates for 1991 indicated that the mean distance to the nearest health facility was about 4 kilometers.[1] Nor were there significant economic barriers to contraceptive use, as most family planning services were and continue to be offered free of charge. However, the contraceptive procurement and distribution system was largely dysfunctional, and few service providers at Government health facilities had been trained in the provision of modern contraceptive services. Thus, despite nearly universal physical access to health facilities, access to modern family planning service and contraceptive supplies was limited.

Since 1992 when the National Population Policy was implemented, the situation has changed dramatically. The regular availability of multiple modern contraceptive methods at government health facilities has become the rule rather than the exception, and the number of health providers in government facilities having received formal training in the provision of modern contraceptive methods has increased four-fold.[2]

Despite these improvements in the supply environment for family planning services, the level of unmet need/demand for family planning services in Tanzania remains high. Estimates from the 1996 Demographic and Health Survey (DHS) indicate that 23.9 percent of currently married Tanzanian women desired to either postpone their next birth by at least two years or not to have any additional children, but were not using a contraceptive method.[3] In fact, despite the significant improvements in the availability of contraceptive methods and trained service providers

at government health facilities that have taken place in the 1990s, the level of unmet need has declined only slightly since the early 1990s (estimated level in 1991 = 29.8 percent of women of reproductive age).

What might explain these persistently high levels of unmet need for family planning? One possibility, the subject of the present study, is the existence of service provider-imposed obstacles to the use of contraception. Relevant examples of such obstacles include inappropriate contraindications, provider-imposed eligibility restrictions, unnecessary process hurdles, need for overspecialized providers, provider bias, and regulation.[4] These obstacles are potentially important because they can affect both the access to and the quality of family planning services – they can result in the denial of services to women, higher psychic and time costs for women using services, and restrictions on the choice of methods.[5] While many of these obstacles are the result of cultural attitudes and norms of practitioners, recent studies have characterized such obstacles as "medical barriers," since they are restrictions that are imposed by family planning providers, often with unfounded medical justifications.[6]

Several prior studies have documented the magnitude of and the potential adverse impact of medical barriers on contraceptive access in public sector family planning programs in developing countries. Studies in Kenya and Nigeria, for example, document blatant provider biases including providers denying services to youth on the basis of age, number of children, and marital status.[7] Another study conducted in Pakistan revealed that about one-third of all women would not be eligible to use hormonal contraceptives as a result of popular misconceptions about age and parity requirements.[8]

The presence of provider barriers that unnecessarily restrict access to clients is clearly of concern to Tanzanian family planning authorities. In 1994, the Family Planning Unit of the

Ministry of Health instituted the National Policy Guidelines and Standards for Family Planning Services and Training. The guidelines stipulate that "all males and females of reproductive age, including adolescents irrespective of their parity and marital status, shall have the right of access to family planning information, education, and services." [9] To date, however, no systematic assessments have been undertaken as to the extent to which such barriers persist. In this article, we attempt to fill this information gap by investigating the presence of medical barriers at Government family planning service delivery points and assess the consequences of these for Tanzanian women seeking family planning services.

Data and Methods

Data for the study were obtained from the 1996 Tanzania Service Availability Survey undertaken by the Government of Tanzania's Bureau of Statistics with technical assistance provided by the USAID-funded EVALUATION Project of the University of North Carolina at Chapel Hill. The survey included five instruments: (1) a facility observation instrument; (2) a facility interview; (3) a facility procedures and practices questionnaire; (4) a service provider questionnaire; and (5) an exit interview for female family planning clients. The data used in this study were obtained primarily from the service provider questionnaire and the facility procedures and practices questionnaire. These two instruments provide rich information on whether the facility provides family planning, and whether medical staff within facilities report certain types of medical barriers.

This analysis focuses specifically on government service delivery points, which are the source of family planning methods for 74 percent of Tanzanian women who use modern family planning methods.[10] The three referral levels covered in the survey are dispensaries, health centers, and hospitals. Dispensaries, which are the most common type of facility, are mainly staffed by

rural medical aides, auxiliaries, and an MCH aide. Health centers usually have at least one medical assistant in addition to medical aides, a trained midwife, MCH aides, auxiliaries, and in some cases, nurses. Hospitals can include district, regional, and consulting facilities, and are usually staffed by doctors and nurses, in addition to the other types of personnel listed above.

For urban areas, data are available from 126 government facilities that provide family planning (35 hospitals, 38 health centers, and 53 dispensaries). For rural areas, data are available for 241 government facilities that provide family planning (24 hospitals, 76 health centers, and 141 dispensaries). At the provider level, data are available for 343 urban family planning providers and 542 rural providers.[a]

For the purposes of the study, medical barriers are defined as practices, derived at least partly from a medical rationale, that result in a scientifically unjustifiable impediment to, or denial of, contraception.[11] Medical barriers may be imposed at the national regulatory level, at the program policy level, or at the individual provider level. Six types of medical barriers, which are described briefly below, have been discussed in the literature:[12] contraindications, eligibility, process hurdles, overspecialized providers, provider bias, and regulation.

Contraindication barriers are based on misinformation on diseases that may be associated with risks of a method, and prevent the recommendation of the specific method. For example, many providers falsely believe that women with diabetes, varicose veins, and epilepsy should not use hormonal methods and are thus unwilling to prescribe oral contraceptives to these women.

Eligibility barriers include prohibitions on use of a family planning method based on age, parity, marital status, and spousal consent. For example, some providers may consider it inappropriate to provide an IUD to a woman who has no children, even if she is not at risk of acquiring a STD.

Process hurdles include physical examinations and laboratory tests as an unjustifiable prerequisite for the initiation or continuation of use. For example, a provider may require a pelvic exam to obtain contraceptives, or delay the provision of services until the woman has had her next menstrual period.

Overspecialization -- in many scenarios, providers with a high level of formal education, such as doctors and nurses, are often required for provision of clinical methods, even though trained personnel with limited formal education are capable of providing most specialized procedures.[13] In rural areas where specialists are less likely to practice, availability of clinical methods may be more limited if only specialists are deemed appropriate to provide services.

Provider bias includes the practice of favoring some methods and discouraging others in the absence of a sound medical rationale, as well as failing to ascertain and consider the preferences of the client.

Regulatory restrictions may be based on religious controls, health concerns, economic control, or lack of approval of the contraceptive by the government that is providing the services.

The data available for the present study permit us to assess four of the six types of barriers described above – the data do not provide adequate information to examine contraindication and regulation barriers. It should be noted, however, that in view of recent policy developments in Tanzania, the remaining regulatory barriers are few.

Findings

To provide context for understanding how provider barriers contribute to restricting access to contraceptives in Tanzania, Table 1 provides information on contraceptive methods offered at government health facilities in 1996. These data indicate that supply methods (pills, injectables,

condoms, and foaming tablets) tend to be widely available in public-sector facilities, both urban and rural. Note, however, that the IUD is primarily available in hospitals. Implants and both female and male sterilization were also most typically available in hospital settings. Because of low availability of implants, diaphragms, and female and male sterilization, we focus our attention on the remaining supply and clinical methods.

Utilization of supply methods requires women to return to the facility every one to three months either to replenish their supply, or to receive another injection. True availability of these methods depends on whether or not the methods are in stock when women visit the specific family planning service delivery point. An analysis of the percent of government facilities reporting stock-outs of each method indicated that the methods with the greatest supply problems are pills and injectables, the two most commonly used methods by Tanzanian women (results not shown). Of the facilities that offer these methods, 18 percent reported a stock-out of injectables and 15 percent a stock-out of pills in the month prior to the survey. Levels of stock-outs were lower for condoms (12 percent).[b]

These data indicate that although significant improvements have been made in commodities and logistics management during the early 1990s, there is room for further improvement. The majority of facilities appear, however, to have a sufficient regular supply of the contraceptives methods used most frequently by Tanzanian women.

Provider Over-Specialization Barrier

Because it is a common practice that doctors and nurses, and not other types of providers, insert IUDs and implants,[14] the type of provider available at a particular facility is likely to be an important determinant of the choice of methods that are available to clients. Table 2 indicates the

percentage distribution of government family planning personnel by type of provider, which is likely to be a good proxy of formal education, but not necessarily of training in the provision of family planning methods. As may be observed, in rural areas only a small fraction of providers are doctors or nurses; more than half (52 percent) of all providers are either trained midwives or MCH aides. MCH aides also make up a large share of providers in rural health centers and dispensaries, but medical assistants and auxiliary staff members are also important at these types of facilities.

As in rural areas, only a minority of the staff in urban health facilities are doctors or nurses, although the proportion is much higher than in rural areas. In urban hospitals, nurses, MCH aides and trained midwives have the greatest representation as a proportion of total staff, while in urban health centers and dispensaries, proportionally more providers are MCH aides, a consequence of the emphasis on providing family planning and well-baby care within these facilities.

That doctors and nurses are primarily located in hospitals is one factor leading to restricted availability of IUDs and implants in health centers and dispensaries. Other factors include lack of equipment or supplies to provide these methods. Specific IUD and implant training of less technical medical staff, including midwives, and improvements in facility infrastructure would result in these methods being more accessible outside the hospital setting. By providing training to MCH aides and medical assistants, it is possible that these providers could insert IUDs and implants without requiring that health centers and dispensaries increase the number of doctors or nurses. Indeed, providers who participated in a FP/RH training course between 1992 and 1996 are found to be four times more likely to offer IUDs than providers who did not receive this standardized training (85 percent vs. 23 percent).[15] Moreover, trained providers are also slightly more likely than untrained providers to offer oral contraceptives (96 percent vs. 90 percent), condoms (97 percent vs. 88 percent), and injectables (95 percent vs. 87 percent).[16]

Eligibility Barriers

Even if a client visits a facility with the appropriate equipment and supplies and providers are trained and qualified to provide a wide range of family planning services, the client may be unable to obtain family planning if providers refuse services to clients who do not meet certain criteria. This section explores the extent to which government providers in Tanzania restrict access on the basis of age, parity, marital status, and consent of spouse.

Table 3 shows the percentage of providers who report restricting access to each method on the basis of an age criterion by type of provider and urban/rural location. For each method, we classify medical staff who report denying access to clients between 12 and 55 years of age as inappropriately restricting access. These data indicate that quite a high proportion of providers restrict eligibility by age, particularly for oral contraceptives, which is the most widely used method by Tanzanian women. Medical aides, trained midwives, MCH aides, and auxiliary staff are most likely to impose age restrictions (79 to 81 percent) for the pill. This is important, because these are the most common types of providers in rural areas. Restrictions are also imposed by staff with higher levels of formal training, with 53 percent of doctors and 71 percent of nurses reporting age restrictions.

Because the condom is a barrier method with no hormonal side effects, fewer restrictions might be anticipated. While this expectation is borne out by the data, nevertheless more than a third of providers reported age restrictions. The remaining methods all have similar levels of restrictions by type of provider and across rural and urban areas. These restrictions are not medically recommended, and thus represent social barriers presented within a medical context.

Table 3 also provides information on the mean minimum and maximum age barriers reported by providers. The mean maximum age barrier is roughly 43 - 45 years for most female methods (similarly for female and male sterilization - results not shown). This may be an important barrier for older women who want to limit their family size but are not provided with the most effective methods to attain their reproductive goals. The mean minimum age barrier is roughly 14 - 15 years, limiting access of most methods to young, sexually active women and putting them at risk of unwanted premarital births. While condoms have the lowest mean age restrictions (14 years of age), this cutoff may restrict access to adolescents who tend to have infrequent sex and may change partners often[17] and thus need barrier methods to prevent against STDs and unwanted pregnancies.

Table 4 indicates the proportion of providers reporting restrictions based on the number of children ever born. There is no medical justification for limiting any method on the basis of parity, assuming that appropriate counseling is provided.[18] Unlike age restrictions, parity restrictions on the use of condom are low or non-existent. However, restrictions on female methods are more common, particularly for the pill, the IUD, and injections. Based on parity, medical aides, MCH aides, and auxiliary staff appear to be the most conservative in the distribution of methods. For example, 35 percent of medical aides, 24 percent of MCH aides and trained midwives, and 32 percent of auxiliary workers reported using parity to restrict the provision of injections. Moreover, some rural providers appear to be more conservative than urban providers, specifically for injections and the pill. Overall, parity restrictions appear to be more important in rural areas, not only because rural providers are more conservative, but also because the most conservative providers (medical aides and auxiliary staff) tend to be the most common providers of family planning in rural areas.

Table 4 also reports the mean number of children required among those staff who report parity restrictions. For the majority of the supply methods (pill, injection, and condom), the mean number of children reported as needed prior to providing a method is about 2.5. This restricts access to young, unmarried women and men who may need these supply methods. On the other end of the spectrum, providers who restrict sterilization or vasectomy on the basis of parity report that a woman must have, on average, four to five children before these methods are provided (results not shown).

Another potentially important eligibility barrier is restricting access on the basis of marital status. Table 5 indicates the proportion of providers who use marital status to restrict access to family planning methods, by type of method and by type of provider. The methods for which providers are most likely to restrict access are the IUD and injections, which are attractive spacing or delaying options for sexually active young women who may not be married. In rural and urban areas, medical aides, MCH aides, and auxiliary medical staff are the most likely to restrict access to all methods by marital status. This is specifically a problem in rural areas and in urban dispensaries where these are the most common types of providers of family planning.

The final eligibility barrier considered is spousal consent. Generally, for most methods few providers require spousal consent (Table 6). Once again, medical aids and auxiliary medical staff in rural areas are the most likely to report spousal consent requirements, followed by MCH aides. Medical aides are the most likely providers to report consent requirements in urban areas, but given that medial aides are the least common providers of family planning in urban hospitals, health centers, and dispensaries, this is not viewed as a substantial problem.

Each of the eligibility barriers discussed above represent social barriers to access rather than true medically recommended restrictions. While the government of Tanzania has explicit

guidelines that require access to all methods at government facilities for anyone who can cause or carry a pregnancy, it is clear that this is often not the case. Providers who have certain preconceptions of who should or should not receive services cause lower access at the facility level. Among the eligibility barriers, age barriers are the most important. Of the 363 facilities in this study, only 10.7 had no provider reporting an age barrier (results not shown). Thus, a young woman who requests family planning may be turned away in many cases if she arrives at a facility with one or more providers who restrict access on the basis of age. For the other eligibility barriers, the percentages of facilities with no barriers are greater (47.7 percent with no provider reporting parity restrictions, 54.5 percent for marriage restrictions, and 59.2 percent for consent restrictions). Differences between rural and urban areas were small with generally a greater percentage of facilities with no providers who report restrictions in urban areas.

Provider Bias

Another way service providers may limit access to methods is through provider bias. We operationalize provider bias with the measure of whether a provider reports never recommending at least one type of modern method that is offered at the facility at which they work. Figure 1 indicates how common it is for providers in the Tanzania Service Availability Survey to report that they would never recommend a particular method. Among respondents for the present study, 10 to 13 percent reported that there is at least one modern method they would never recommend, with little variability by type of provider and urban/rural location. The larger percentages for doctors could be a consequence of the small number of physicians in the sample (the difference is not statistically different from the other providers). When examined at the facility level, of the 363 facilities in this study, 23.4 percent have at least one provider who reported that they would never

recommend a method. Thus, women who visit a government family planning service delivery site risk falling upon a biased provider in a quarter of the facilities in this study.

Among those providers who report not recommending at least one method, "female" methods (injections, pill, and IUD) were the methods least likely to be recommended (data not shown). The particular non-recommended methods vary by urban/rural location. In urban areas, injections, implants, IUDs, and the pill were the most common methods that were reported to be never recommended. There was less bias towards female methods in rural facilities, where the method most commonly reported as never being recommended was the condom. Thus, while women may have greater access to female hormonal methods in urban areas because more methods are offered and there are better trained providers, providers may choose not to recommend some methods, resulting in a barrier to women attaining the best method for their specific family planning needs.

Process Hurdles

The final medical barrier we examine is process hurdles. One process hurdle is the requirement that a woman wait until her next menstrual period before receiving the pill, having an IUD inserted, or receiving her first injection. Generally, this waiting time is not appropriate if it is possible to confirm that the woman is not pregnant through a simple test prior to prescribing these methods.[19] Asking all women to delay adoption of these methods may result in a lower adoption rate at the later date due to the cost and inconvenience of returning to the facility. To examine process hurdles, information on how providers screen patients who want hormonal methods is used. Among providers who work in facilities where hormonal methods are supplied, 60.4 percent report using a pregnancy test prior to providing the pill or another hormonal method to a woman not

having her menses – 64.5 percent in urban areas and 57.4 percent in rural areas. This is an appropriate strategy for providing hormonal methods during the client's current facility visit.

Table 7 provides information on alternative strategies used by providers who did not mention pregnancy tests for provision of hormonal methods. The table covers 417 providers who did not mention pregnancy testing (156 from urban areas and 261 from rural areas). The most common strategy mentioned (35 percent) was to ask the client to return at next menses. While this strategy rules out pregnancy in rural areas where pregnancy tests may be unavailable or expensive, it is not ideal because it does not adequately meet the needs of women who do not want to have children but are at risk of a subsequent birth. The better option would be to supply condoms and ask the client to return (as reported by 32 percent of these providers), although this is also less than fully satisfactory as there is no guarantee that condoms will be used in the interim until next menses, nor that the client will return at all. The other common practice mentioned by providers who do not report pregnancy testing was to supply the hormonal method (30.5 percent of providers). This option is not medically recommended because some women may be currently pregnant and the pill, injection, or IUD could negatively affect this current pregnancy. While the majority of providers (60 percent) mentioned that ruling out the pregnancy is a strategy employed, among those providers who did not mention this strategy, process hurdles appear important because clients are either required to return to the facility or asked to temporarily use a method that may not suit their and their partner's needs.

Implications of Provider Barriers at the Facility Level

The discussion to this point has focused on the extent to which individual service providers restrict access to family planning. In this section, we assess the consequences of these individual provider barriers considered in the aggregate using health facilities as the unit of analysis. The intent is to

simulate what would happen to a hypothetical woman with specified characteristics appearing at a public sector facility in Tanzania seeking a particular contraceptive method. As our interest is in provider-imposed barriers, we confine our attention to methods that are offered by each sample facility. The outcome measure used in this analysis is the proportion of facilities that are "barrier-free;" that is, have no unjustified barriers given a client's characteristics and method choice measured across all service providers interviewed at each sample facility.[c] Of course, in facilities where multiple service providers are based, the outcome of a client visit would depend in some cases upon which service provider the client encountered, and thus our estimates may over-state the likelihood that a given client would encounter unjustified barriers. However, as there is no guarantee that a given client would encounter those service providers who do not impose barriers, the indicator used provides a reasonable measure of risk of encountering barriers.

The results of this facility-level analysis are presented in Table 8. Given space constraints, we discuss the scenario of a non-pregnant woman desiring oral contraceptives, the most widely used contraceptive method by Tanzanian women. The results are similar for other widely used methods.

Consider first a 15 year-old adolescent who is unmarried and wants to obtain the pill at a government facility. The results shown in Table 8 indicate that at less than one-half of all facilities would this client not encounter any providers who restrict access. If the same woman was instead 20 years of age, 59 percent of urban facilities and 54 percent of rural facilities have no provider who would restrict access. If this 20 year old woman was not menstruating at the time of her clinic visit, then in only 28 percent of urban and 19 percent of rural facilities would she encounter no barriers (as defined by age restrictions, parity restrictions, and inappropriate screening prior to the provision of services).

Providers are more likely to provide services to married women in their 20's and 30's. For example, over 80 percent of facilities are barrier-free for a 20 year old married woman who wants the pill, compared to between 54 and 59 percent of urban and rural facilities, respectively, for women who are unmarried. However, if this same woman does not have the consent of her husband, she is not as likely to obtain oral contraceptives, as less than two-thirds of facilities are without barriers in this case.

While married women in their 30's with several children are more likely to obtain the pill because there are few providers who restrict access, women in their 40's tend not to be as fortunate. For example, the percentage of facilities without barriers for a married woman age 30 with four children who wants the pill is 95 percent in urban areas and 93 percent in rural areas. For a 40-year old woman who also has four children and wants the pill, however, only 49 percent of urban facilities and 60 percent of rural facilities are barrier-free.

Discussion

In the 1990s, the Government of Tanzania has taken a number of significant steps aimed at providing universal access to modern family planning services in Tanzania. At the policy level, the National Population Policy and the National Policy Guidelines and Standards for Family Planning Services and Training were introduced in 1991 and 1994, respectively. At the program or implementation level, improvements were made in the family planning commodities and logistics system, significantly improving the availability of contraceptive methods at government health facilities, and large numbers of service providers have been trained in the provision of family planning services.

While these actions have reduced and even eliminated some barriers to contraceptive access, the findings of the present study indicate that other barriers that are not typically reflected by program indicators of accessibility (e.g., distance to facilities, number of methods offered, prevalence of stock-outs) persist. These barriers, which are imposed by individual service providers with neither government policy endorsement nor valid medical justification, serve to restrict access to contraceptive methods in Tanzania in important ways. The age barriers faced by young unmarried women and the process hurdles faced by women of all ages seeking hormonal methods merit special attention, the former because adolescents have been identified as a target population that should be guaranteed access to family planning services,[20] and the latter because of the high proportion of Tanzanian women who rely on hormonal methods.

The existence of unnecessary provider barriers is the result of a number of factors, including the quality of training received by providers and the socio-cultural attitudes and norms of the environment in which providers practice. The data presented above suggest that the Tanzanian National Family Planning Program, having made considerable progress in providing women with physical and economic access to health facilities with adequate supplies of multiple contraceptive methods, must now shift focus to what happens to clients once they arrive at government facilities for services. The key to further improvements in access would appear to hinge largely upon the success of efforts to reduce and ultimately eliminate the barriers encountered by potential clients once they are inside facility doors.

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Notes

a In the tables presented, the number of providers and facilities are sometimes less than these values due to missing information from providers or facilities.

b These findings should be interpreted cautiously. While the depletion of supplies may be a result of inefficiency within the government sector, it may also be true that a facility experiences stock-outs because demand is high. Sorting out the reasons for the frequency of facility stock-outs is beyond the scope of this analysis.

c Based on the sample of provider interviewed at each facility.

Figure 1: Percentage of Family Planning Providers Who Report Not Recommending At Least One Method.

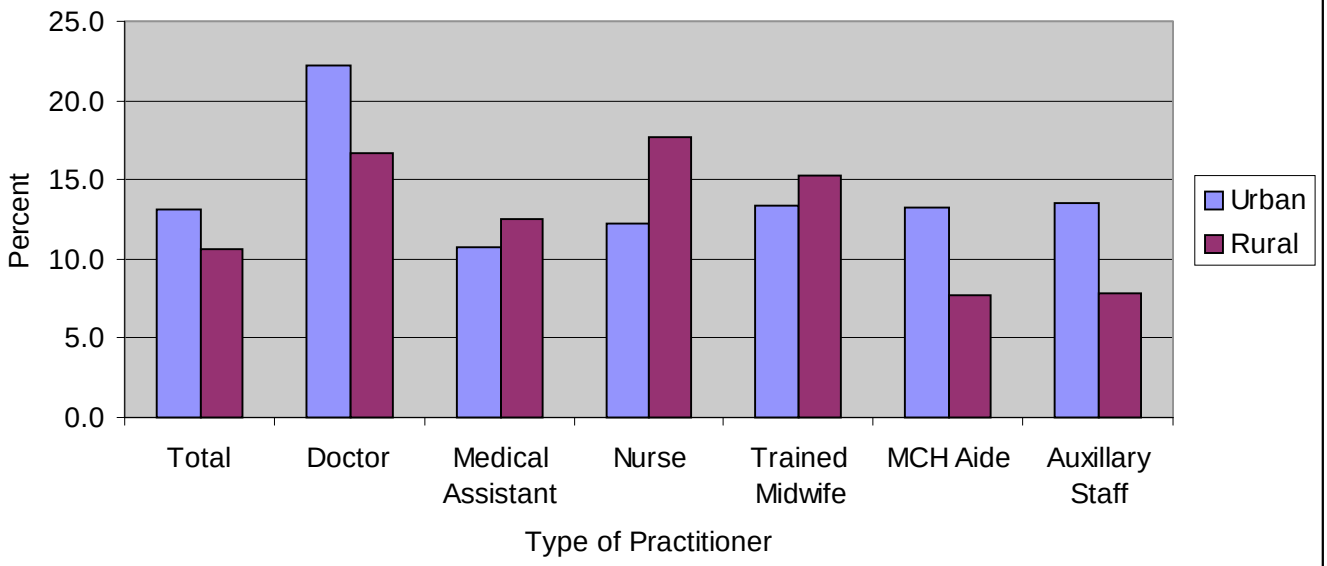

Table 1: Percentage of Government Facilities Offering Family Planning Services, by Type of Method, and by Urban/Rural Status

	Urban				**Rural**			
Type of Method	Urban Total (N=126)	Hospital (N=35)	Health Center (N=38)	Dispensary (N=53)	Rural Total (N=241)	Hospital (N=24)	Health Center (N=76)	Dispensary (N=141)
Total Number	126	35	38	53	241	24	76	141
Pills	98.1	94.3	100.0	100.0	100.0	100.0	100.0	100.0
Injectables	98.1	94.3	100.0	100.0	99.5	100.0	100.0	98.6
Implants	11.8	35.3	0.0	0.0	9.5	25.0	2.7	0.7
IUD	69.2	94.3	70.3	43.1	56.5	91.7	65.8	12.1
Condoms	97.4	94.3	100.0	98.0	98.7	100.0	100.0	96.0
Foaming Tablets	84.9	94.3	83.8	76.5	72.7	91.7	72.4	54.0
Diaphragm	16.4	28.6	10.8	9.8	4.9	8.3	2.6	3.7
Female Sterilization	29.5	85.7	2.7	0.0	27.2	75.0	6.6	0.0
Male Sterilization	13.7	41.2	0.0	0.0	13.4	37.5	2.6	0.0
Natural Family Planning	68.4	79.4	64.9	60.8	67.0	79.2	72.0	50.0

Table 2: Percentage Distribution of Government Family Planning Providers, by Type of Provider, by Type of Facility, and by Urban/Rural Status.

	Urban				Rural			
Type of Provider	Total (N=343)	Hospital (N=133)	Health Center (N=101)	Dispensary (N=109)	Total (N=542)	Hospital (N=87)	Health Center (N=169)	Dispensary (N=286)
Doctors	2.3	6.0	0.0	0.0	2.2	11.5	1.2	0.0
Medical Assistants	7.9	3.8	10.9	10.1	17.5	2.3	13.0	24.8
Nurses	19.0	30.1	13.9	10.1	6.3	24.1	4.7	1.8
Trained Midwives	23.0	25.6	29.7	13.8	15.7	31.0	24.9	5.6
MCH Aides	36.7	29.3	34.7	47.7	36.7	27.6	45.0	34.6
Auxiliary Staff	11.1	5.3	10.9	18.4	21.6	3.5	11.2	33.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Table 3: Percentage of Government Providers Who Restrict Eligibility by Age, by Type of Method, and by Urban/Rural Status, and Mean Minimum and Maximum Age Restrictions

	Type of Provider							
Type of Method	Doctors	Medical Aides	Nurses	Trained Midwives	MCH Aides	Auxiliary	Mean Min. Age	Mean Max. Age
Total								
Pill	52.9	79.2	71.1	81.0	78.9	80.3	14.6	42.1
Condom	37.5	48.7	38.2	36.7	41.2	45.6	14.1	50.0
Sterilization	40.0	0.0	10.0	14.3	20.0	33.3		
IUD	46.7	72.0	60.6	60.0	62.4	77.8	15.0	43.4
Injection	42.9	80.2	62.2	67.5	63.7	68.7	15.5	43.6
Vasectomy	100.0	NA	66.7	NA	NA	NA		
Urban								
Pill	33.3	73.1	66.7	80.3	86.2	81.6		
Condom	33.3	37.0	37.9	34.7	46.7	50.0		
Sterilization	33.3	0.0	9.1	20.0	50.0	33.3		
IUD	16.7	58.3	64.3	66.7	69.1	80.0		
Injection	33.3	73.1	61.7	66.7	66.7	75.7		
Vasectomy	NA	NA	100.0	NA	NA	NA		
Rural								
Pill	63.6	80.9	80.0	81.7	74.2	79.8		
Condom	40.0	52.2	38.7	38.6	37.7	44.0		
Sterilization	50.0	NA	11.1	0.0	0.0	NA		
IUD	66.7	84.6	54.2	52.6	54.4	75.0		
Injection	50.0	82.2	63.3	68.3	61.8	66.4		

Table 4: Percentage of Government Providers Who Restrict Eligibility by Parity, by Type of Method, and by Urban/Rural Status, and Mean Parity Restrictions

	Type of Provider						Mean
Type of Method	Doctors	Medical Aides	Nurses	Trained Midwives	MCH Aides	Auxiliary	Minimum Parity
Total							
Pill	11.8	21.7	6.7	12.7	18.9	29.0	2.4
Condom	0.0	4.2	0.0	1.9	3.9	7.5	2.4
Sterilization	40.0	0.0	15.0	14.3	40.0	0.0	
IUD	21.1	23.2	12.5	16.8	22.6	30.9	1.7
Injection	14.3	34.5	17.8	23.6	23.9	32.0	2.7
Vasectomy	100.00	NA	33.33	NA	NA	NA	
Urban							
Pill	16.7	19.2	6.7	15.8	19.5	21.1	
Condom	0.0	3.7	0.0	2.7	2.5	10.5	
IUD	25.0	8.0	15.9	21.3	24.1	20.0	
Injection	16.7	26.9	20.0	21.3	19.5	24.3	
Rural							
Pill	9.1	22.3	6.7	9.8	18.6	31.6	
Condom	0.0	4.4	0.0	1.2	4.7	6.4	
IUD	18.8	28.6	6.1	12.2	21.6	34.8	
Injection	12.5	36.7	13.3	25.6	26.7	34.6	

Table 5: Percentage of Government Providers Who Restrict Eligibility by Marriage, by Type of Method, and by Urban/Rural Status

Type of Method	Type of Provider: Doctors	Medical Aides	Nurses	Trained Midwives	MCH Aides	Auxiliary
Total						
Pill	25.00	19.17	8.99	5.70	12.93	21.38
Condom	20.00	16.10	13.64	2.53	10.71	13.38
Sterilization	40.00	0.00	46.15	33.33	50.00	50.00
IUD	23.08	28.00	12.50	18.75	17.53	22.22
Injection	15.38	28.70	17.98	12.18	20.06	26.87
Vasectomy	0.00	NA	0.00	NA	NA	NA
Urban						
Pill	16.7	19.2	10.2	5.3	9.8	8.1
Condom	16.7	19.2	15.8	4.0	10.1	10.8
Sterilization	66.7	0.0	55.6	25.0	50.0	50.0
IUD	20.0	33.3	12.5	19.1	13.2	20.0
Injection	16.7	26.9	18.6	6.8	18.2	18.9
Vasectomy	NA	NA	0.0	NA	NA	NA
Rural						
Pill	30.0	19.2	6.7	6.1	15.0	25.9
Condom	22.2	15.2	9.7	1.2	11.1	14.3
Sterilization	0.0	NA	25.0	50.0	50.0	NA
IUD	25.0	23.1	12.5	18.4	22.7	25.0
Injection	14.3	29.2	16.7	17.1	21.3	29.9
Vasectomy	0.00	NA	0.00	NA	NA	NA

Table 6: Percentage of Government Providers Who Restrict Eligibility by Consent of Husband, by Type of Method, and by Urban/Rural Status

Type of Method	Type of Provider: Doctors	Medical Aides	Nurses	Trained Midwives	MCH Aides	Auxiliary
Total						
Pill	6.25	25.83	4.49	7.64	15.19	37.06
Condom	13.33	16.95	6.90	9.49	14.01	31.43
IUD	15.38	16.00	1.56	5.00	7.14	33.33
Injection	16.67	25.86	5.62	7.69	14.52	34.85
Urban						
Pill	0.00	42.31	3.39	6.67	11.38	32.43
Condom	0.00	23.08	3.51	12.00	9.24	29.73
IUD	0.00	25.00	2.50	4.76	7.41	40.00
Injection	0.00	23.08	3.39	8.11	10.92	30.56
Rural						
Pill	10.00	21.28	6.67	8.54	17.62	38.68
Condom	22.22	15.22	13.33	7.23	17.02	32.04
IUD	25.00	7.69	0.00	5.26	6.82	25.00
Injection	28.57	26.67	10.00	7.32	16.85	36.46

Table 7: Percentage of Family Planning Providers* that Report Using Screening Strategies Other than Pregnancy Tests When Providing Hormonal Methods (N=417).

Screening Strategy	Total	Urban	Rural
Ask client to return at next menses	34.5	25.0	40.2
Try to induce menses	19.7	21.2	18.8
Supply condoms and ask to return	31.9	35.9	29.5
Supply hormonal method	30.5	34.0	28.4
Supply hormonal method and condoms	18.7	29.5	12.3

Note: The sample in this table is restricted to family planning providers who both work in a facility providing hormonal methods and report not administering pregnancy tests when providing hormonal methods.

Table 8: Percent of Government Facilities Without Provider Barriers for Women with Specified Characteristics.

Hypothetical Characteristics	Urban (N=123)	Rural (N=238)
Wants Oral Contraceptive Pill, Not Pregnant		
Age 15, unmarried, no children	43.9	43.3
Age 20, unmarried, no children	58.5	54.2
Age 20, unmarried, no children, not menstruating	28.4	19.3
Age 20, unmarried, one child	68.3	60.9
Age 20, married, one child	82.9	80.7
Age 20, married, one child, no husband consent	64.2	58.8
Age 30, married, four children	95.1	93.3
Age 40, married, four children	48.8	59.7
Wants Injection, Not Pregnant		
Age 15, unmarried, no children	36.6	35.3
Age 20, unmarried, no children	52.8	41.6
Age 20, unmarried, no children, not menstruating	23.6	17.6
Age 20, unmarried, one child	56.9	49.6
Age 20, married, one child	72.4	66.0
Age 20, married, one child, no husband consent	60.2	50.0
Age 30, married, four children	88.6	90.3
Age 40, married, four children	74.0	75.2
Wants Condom		
Age 15, unmarried, no children	61.8	62.2
Age 20, unmarried, no children	74.0	75.6
Age 20, unmarried, one child	75.6	76.5
Age 20, married, one child	95.1	95.4
Age 20, married, one child, no husband consent	73.2	68.1
Age 30, married, four children	99.2	98.7
Age 40, married, four children	95.9	96.2
Wants IUD, Not Pregnant		
Age 15, unmarried, no children	43.1	55.0
Age 20, unmarried, no children	60.2	63.0
Age 20, unmarried, no children, not menstruating	24.4	24.4
Age 20, unmarried, one child	69.1	71.8
Age 20, married, one child	85.4	82.4
Age 20, married, one child, no husband consent	74.0	75.2
Age 30, married, four children	95.1	94.1
Age 40, married, four children	77.2	81.5

Note: Above scenarios assume method is available in all facilities.