Reducing Provider Restrictions using Values Clarification Approach

Akiode A[1]., Oluwaghohun O[1]., Odeku M[1]., Akiode. N[1]., Akinso S[1]

JHCCP/Nigerian Urban Reproductive Health Initiative[1]

Presenter: Akiode A., aaakiode@nurhi.org, 08037162598

Background:
In Nigeria, use of modern family planning remains low, at about 10%, Nigeria remains one of the countries with the lowest Contraceptive Prevalence Rate (CPR). When economic, access and quality related barriers are eliminated, sometimes women seeking contraceptive services are not able to receive the methods they desire because of medical barriers imposed by service providers. To address this provider imposed barriers, the Nigerian Urban Reproductive Health Initiative, during its training of health care providers in competency based family planning trainings, introduced a values clarification exercise that focuses on addressing these restrictions. In this paper, we compared how these restrictions have changed among providers in NURHI high volume sites between baseline survey in 2010 and endline survey in 2014.

Methods:
Data was drawn from the baseline (2010) and endline (2014) health facility survey conducted by an independent institution, the Measurement Learning and Evaluation Project (MLE) funded by the Bill and Melinda Gates Foundation (BMGF). A longitudinal sample of health facilities were surveyed at both times. Data for this paper was from about 400 respondents from provider survey component of the study. We assessed whether providers were imposing restrictions based parity, marital status, consent of others and age. We assessed these restrictions for all contraceptive methods. Chi-Square test was used to compare data between baseline and endline.

Results:
Restriction based on parity reduced significantly for all contraceptive methods from baseline in 2010 to endline in 2014. Specifically, proportion of provider's that do not offer male condoms based on parity of the client reduced from 45% at baseline to 2% at endline in 2014. Restrictions based on parity for oral pills reduced from 32% in 2010 to 26% in 2014. Also the proportion of providers that imposed restrictions for all other contraceptive methods based on parity changed significantly across board. For marital status, provider restrictions reduced significantly for all methods from baseline to endline. Also, the proportion of providers that will not provide a method based on certain age reduced for all methods from baseline in 2010 to endline in 2014. The proportion of providers that do not offer certain methods unless the client of up to certain age reduced from baseline and endline for all the methods except for oral pills, injectables and IUDs.

Conclusions
Our results showed that family planning providers continue to impose unnecessary restrictions on family planning provision for most FP methods. Values clarifications during training combined with in person supervision can play

a critical role in reducing these restrictions. Future trainings should explore the possibilities of incorporating values clarifications exercises that specifically addresses these restrictions, also program managers need to reemphasize these learnings during supportive supervision managers. FP providers remain a primary target for FP programming and the need to achieve postitive norms among them cannot be exaggerated.