

**Measurement of Access to Family Planning Services:
What do we measure? What do we want to measure? How do we get there?**

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INTRODUCTION

In recent years, there has been a dramatic increase in the number of published research papers related to access to family planning (FP).¹ A casual search of the terms “access to contraception” and “access to family planning” in PubMed reveals that the last two years have witnessed a boom in articles published related to the topic. The 2012 high of 197 “access to contraception / access to family planning” published articles was surpassed in 2013 with 241 articles. Compared with the average yearly number of publications meeting this basic criteria in the 2000s (n=105) and this crude metric reveals that academic interest in access to FP is growing. In conjunction with the research community’s increased attention to access, the programmatic and policy communities have also embraced access to FP as a driving paradigm, as made evident at the 2012 London Summit on Family Planning, where the leaders of 150 countries, international agencies, civil society organizations, foundations, and more endorsed the goal of “expanding access to family planning to an additional 120 million women and girls by 2020.”² Focus on expanding FP access is sharpening, however, the definition and measurement of access to FP remains nebulous.

Our study aims to bring clarity to the measurement of access to FP by exploring how the world’s largest and most enduring population and health data source for less developed countries—the Demographic and Health Surveys (DHS)—contributes to the measurement of FP access. Building from World Fertility Surveys, the DHS has become the foremost source of international population and health data, comparable across time and place. Key FP indicators—contraceptive prevalence rate, unmet need for family planning, total fertility rate, age specific fertility rate, median age at first marriage, and more—derive from the population-based household survey.³ Indeed, much of what the world knows about contraceptive use in low income countries stems from DHS data.⁴

In seeking to understand how the DHS contributes to our understanding of FP access, we first document common definitions of access, identify its key domains, and present our synthesized definition of FP access. Thereafter, using the DHS Phase 6 core women’s questionnaire, we catalogue the DHS questions that map to the identified domains of access. We pinpoint the question that elicits the most information on access. We then examine data derived from that question to document common barriers cited, and discuss limitations of these data. Finally, we offer suggestions for improving the measurement of FP access.

BACKGROUND: WHAT DO WE WANT TO MEASURE?

Access has multiple dimensions and varying definitions. In 1981, Penchansky and Thomas defined access to healthcare as “the fit between the patient and the health care system,” as determined by these “Five As”: 1) availability—the provider’s ability to meet the client’s needs, contraceptive stock on hand, personnel on duty, and other resources, 2) accessibility—the geographic location in relation to the client, 3) accommodation—the provider’s ability to meet the constraints and preferences of the client, including office hours and appointment/walk in practices, 4) affordability—the client’s ability and

¹ Family planning is defined as the policies, information, attitudes, practices, services, and commodities, including contraception, that give women, men, couples, and adolescents the ability to prevent pregnancy and choose whether and/or when to have a child.

² FP2020 progress report 2012-2013: partnership in action. Washington, DC: FP2020, 2013.

³ For more information about DHS, see www.dhsprogram.com.

⁴ Fabic MS, Choi Y, and Bird S. A Systematic Review of Demographic and Health Surveys: Data Availability and Utilization for Research. *Bulletin of the World Health Organization*. 2012;90(8): 604–612.

willingness to pay the provider's fee, and 5) accountability—the degree to which the client is comfortable with the provider.^{5,6}

In 1995, Bertrand et. al. attempted to define access to FP specifically, stating that access to FP is “the degree to which family planning services and supplies may be obtained at a level of effort and cost that is both acceptable to and within the means of a large majority of population.” The authors also identified five elements of access: 1) geographic or physical accessibility—the client's geographic proximity to FP services, 2) economic accessibility—the costs of reaching service delivery and supply points and obtaining contraceptive services and supplies are within economic means, 3) administrative accessibility—the extent to which administrative barriers to uptake are eliminated, including restricted clinic hours and unnecessary medical criteria, 4) cognitive accessibility—the extent to which potential clients are aware of locations of services/supply points and availability of services/supplies within those locations, and 5) psychosocial accessibility—the extent to which potential clients are unconstrained by psychological, attitudinal, or social factors in seeking out FP services.⁷

In 2000, the U.N. Committee on Economic, Social, and Cultural Rights (UNCESCR) developed the AAAQ framework to operationalize “the right to the highest attainable standard of health”, which has since been adopted by numerous groups, including most recently FP2020, as a framework for monitoring access.^{8,9} The four elements of the AAAQ framework are: 1) availability—functioning public health and healthcare facilities, goods, and services, as well as programs available in sufficient quantity within the country, 2) accessibility—nondiscrimination, physical accessibility, economic accessibility, and information accessibility, 3) acceptability—all health facilities, goods, and services are respectful of medical ethics and culturally appropriate, and 4) quality—health facilities, services, and commodities are scientifically and medically appropriate and of good quality.

As these descriptions reveal, Five As, Bertrand, and AAAQ have many common elements with a few notable exceptions. Specifically, client agency or the capacity of an individual to act, is described only in Bertrand's model (psychosocial accessibility); the importance of quality is directly mapped out only by the AAAQ model (quality); and the importance of the client's comfort interacting with the provider is described only in the Five As model (accountability). Taken as a whole, these three frameworks indicate that access to FP is manifest at three levels: that of the (potential) client, the provider, and the service delivery point. Categorizing access factors according to the client, provider, and service delivery point levels highlights 11 crucial elements of access:

Service Delivery Points (facility-based/community-based) must:

1. Have geographic proximity to the client
2. Eliminate administrative barriers to uptake, including restricted clinic hours, unnecessary medical criteria, and policies that promote discrimination

⁵ Penchansky R, Thomas JW. The concept of access: definition and relationship to consumer satisfaction. *Med Care*. 1981 Feb;19(2):127-40.

⁶ Leon Wyszewianski. Access to care: remembering old lessons. *Health Serv Res*. Dec 2002; 37(6): 1441–1443.

⁷ Bertrand J.T., Hardee K., Magnani R.J., and Angle M.A. Access, quality of care and medical barriers in family planning programs. *International Family Planning Perspectives*. 1995;21:64-69 & 74.

⁸ UN Committee on Economic, Social, and Cultural Rights. The right to the highest attainable standard of health. 11 August 2000. E/C.12/2000/4. (General Comments).

⁹ Hardee, K., K. Newman, L. Bakamjian, J. Kumar, S. Harris, M. Rodriguez, and K. Willson. 2013. Voluntary Family Planning Programs that Respect, Protect, and Fulfill Human Rights: A Conceptual Framework. Washington, DC: Futures Group.

3. Have appropriate stock on hand, trained providers in place, and facilities in working order
4. Have policies in place that are respectful of medical ethics and culturally appropriate, including, for example, policies that promote voluntarism, informed choice, and protect against undue incentives.

Providers must:

5. Practice nondiscrimination, eliminating barriers to uptake like spousal approval
6. Provide correct, culturally appropriate information and communication
7. Provide medically appropriate care of good quality.

Clients must:

8. Be unconstrained from psychological, attitudinal, or social factors in seeking FP services
9. Have correct, appropriate information to locate services, choose whether to use FP, and choose which method to use
10. Have comfort interacting with the provider
11. Have the ability to pay to reach the service/supply and obtain it.¹⁰

These 11 elements can be broken down even further—the field of social and behavior change communication, for example, has grown to address the psychological, attitudinal, and social factors impacting access—all the more underscoring the complexity of access.

In an effort to simplify, we define FP access as the elimination of barriers to contraceptive uptake and continuation among all who desire to prevent pregnancy, to stop childbearing, or to space their next birth.

METHODS AND RESULTS: WHAT DO WE MEASURE?

Methods

Based on the 11 domains of access identified in the literature and described above, we examined the DHS Phase 6 women’s core questionnaire to pinpoint FP access-related questions and classify those questions by access domain. One of this study’s three coauthors conducted the initial questionnaire review and categorized related questions based on her individual assessment. The two other coauthors reviewed the catalogue and assessment, and offered their own evaluations. Areas of disagreement were minimal. Where divergent opinions arose, the authors discussed amongst themselves and reached consensus.

Table 2 presents FP access-related questions in the DHS core women’s questionnaire by access domain. As Table 2 shows, DHS collects FP access data related only to client-level domains; it does not collect data on either the provider or service delivery point access domains. We identified 22 questions that pertain to FP access. The overwhelming number of DHS questions identified (n=13) relate to one client-level domain—whether (potential) clients have correct, appropriate information to locate services, choose whether to use FP, and choose which method to use. Meanwhile, two components of the DHS questionnaire provide the largest source of information for examining FP access. These two data sources are Q709—Can you tell me why you are not using a method to prevent pregnancy?, and Q311—Can you tell me why you discontinued using a method to prevent pregnancy? Potential answers to these two questions span all four client-level access domains (Table 3).

¹⁰ Note: the affordability element of access is also relevant to the service delivery point domain and could be positioned there as “service delivery points must offer services and supplies that are affordable”.

The respondent sample for Q709 represents sexually active women ages 15-49 years who want to either delay birth by 24+ months or to have no (more) children, but who are not using contraception (Figure 1) whereas the respondent sample for Q311 represents a narrower group of women—women who represent contraceptive discontinuers with an unmet need for family planning. Because Q709 captures the broader spectrum of women with unmet need, as well as the broader spectrum of client-related access factors, we focused our analysis there. Note, in the future, we plan to compare results of Q709 and Q311 to confirm concordance/discordance among women asked both reasons for nonuse and reasons for discontinuation and assess differences between never-users and previous users.

Based on the DHS question mapping exercise, all three coauthors identified one question that spanned the most access domains and captured the most concrete information on FP access—Q709, reasons for not using contraception, which follows a complex skip pattern to identify eligible women. Plotting the skip pattern to that question, we identified which respondents would have been asked to answer it (Figure 1) as well as potential selection bias that the skip pattern may have produced. Thereafter, we explored FP access using data derived from Q709.

Data & Analysis

The study data come from the latest DHS in four selected countries in sub-Saharan Africa that represent a wide range of modern contraceptive prevalence rates (MCP): Zimbabwe (MCP of 57.3 percent), Rwanda (45.1 percent), Ethiopia (27.3 percent), and Senegal (12.1 percent).^{11,12,13,14} Table 1 shows select FP indicators and the number of sampled women by country. In every DHS, all 15-49 year old women in sampled households are identified during the household interview, and are eligible to participate in the women's interview. During the women's interview, information is collected regarding the woman's fertility, contraceptive use, and fertility preference among other things. In the survey section on fertility preferences, the interviewer asks an open-ended question about reasons for not using contraception (Q709), and records answers that the respondent gives based on pre-structured categories (Table 3). The question is asked only among women who do not want a/another child or who want a child in the distant future (i.e., 24 months or later), and do not currently use contraception. Following the skip pattern (Figure 1), ineligible women include those who: never had sexual intercourse¹⁵, are sterilized (or whose partners are sterilized), are currently pregnant, are undecided about whether to have another child, declare they cannot become pregnant, want a child soon (i.e., < 24 months), want a child but in non-numerically identified future (i.e., "after marriage" and "don't know"), and/or currently use contraception.

We assessed the distribution of respondents to Q709 by each eligibility factor, categorizing the respondents according to background characteristics, including age, marital status, and education. We

¹¹ Zimbabwe National Statistics Agency (ZIMSTAT) and ICF International. 2012. Zimbabwe Demographic and Health Survey 2010-11. Calverton, Maryland: ZIMSTAT and ICF International Inc.

¹² National Institute of Statistics of Rwanda (NISR) [Rwanda], Ministry of Health (MOH) [Rwanda], and ICF International. 2012. Rwanda Demographic and Health Survey 2010. Calverton, Maryland, USA: NISR, MOH, and ICF International.

¹³ Central Statistical Agency [Ethiopia] and ICF International. 2012. Ethiopia Demographic and Health Survey 2011. Addis Ababa, Ethiopia and Calverton, Maryland, USA: Central Statistical Agency and ICF International.

¹⁴ Agence Nationale de la Statistique et de la Démographie (ANSD) [Sénégal], and ICF International. 2012. Enquête Démographique et de Santé à Indicateurs Multiples au Sénégal (EDS-MICS) 2010-2011. Calverton, Maryland, USA: ANSD and ICF International.

¹⁵ The skip pattern does not explicitly exclude women who have never had sexual intercourse, however, these women would be excluded from any analysis of data derived from the question.

further examined use of any contraception among ineligible women by exclusion/eligibility factor. Analyses were done for each country separately. All estimates were adjusted for sampling weights.

Results

Table 4 shows the distribution of survey respondents by exclusion criteria for Q709. Among our four countries of analysis, the percentage of eligible women ranged from 20 percent in Zimbabwe to 33 percent in Ethiopia. Table 5 shows background characteristics of women by the eligibility criteria. Across all four countries, women in rural areas and women with little to no formal education were more likely to meet eligibility criteria than urban and/or more educated women. Additionally, across three of the four countries—Rwanda, Ethiopia, and Senegal—women who were not in union were more likely to meet eligibility criteria compared to women in union. Over 99 percent of the eligible women responded to the reason question in each of the four surveys. Although the reasons for nonuse that women cited are not mutually exclusive, the more than 75 percent of women reported only one reason across each of the four country surveys (Table 6).

Among eligible women, reported reasons for not using contraception are presented in Table 7. Across all four countries, three reasons for not using contraception were cited by at least five percent of respondents—not having sex, breastfeeding, and fear of side effects/health concerns. Though 23 response categories are provided, only a handful of answers constitute the majority of responses. In Zimbabwe, two responses accounted for more than 50 percent of reasons cited—not married and not having sex. In Rwanda, three responses accounted for more than 50 percent of all reasons cited—not having sex, being postpartum amenorrheic, and unknown “other”. In Senegal, four reasons accounted for more than 50 percent of all reasons cited—infrequent sex, postpartum amenorrheic, breastfeeding, and respondent opposed. And in Ethiopia, five reasons accounted for more than 50 percent of all reasons cited—not married, not having sex, postpartum amenorrheic, breastfeeding, and fear of side effects/health concerns. Examining the data further aggregated, in spite of ambiguity in some reasons, we see that a large proportion of respondents are not using contraception because they do not believe that they are at risk (ranging from 19.3 percent in Ethiopia to 62.8 percent in Zimbabwe), they are concerned about side effects (6.3 percent in Zimbabwe, 17.5 percent in Ethiopia), they have opposition or experience opposition to contraceptive use (4.4 percent in Rwanda to 26.3 percent in Senegal), or they hold fecundity-related myths (8.4 percent in Zimbabwe to 30.7 percent in Senegal). These four categories represent the major reasons for non-use across all four countries.

Table 8 shows contraceptive method use among women who did not meet eligibility criteria. Large variations in use are observed among women depending on their stated fertility intentions both within and between countries. Within Rwanda, for example, 46.7 percent of sexually active women who are unsure of their fertility intentions report current use of contraception while only 19.3 percent of sexually active women who report that they want another child but are unsure of when report current use of contraception. In Zimbabwe, where modern contraceptive prevalence is relatively high at 58 percent, 56 percent of sexually active women who are unsure of their fertility intentions report current use of contraception. Conversely, in Senegal, where modern contraceptive prevalence is the lowest of our four countries at 12 percent, only 8.4 percent of women who are unsure of their fertility intentions report current use.

DISCUSSION: HOW DO WE GET THERE?

If the FP community is to achieve its ambitious goal of providing FP access to 120 million additional women and girls by 2020, we must make great strides quickly. Recognizing that shorthand terms—like access—are only useful when those using them have a shared understanding of their meaning, we must

first agree upon a common definition of access. We posit that FP access is best defined as: “The elimination of barriers to contraceptive uptake and continuation among all who desire to prevent pregnancy, to stop childbearing, or to space their next birth”, with our list of 11 access domains providing a comprehensive categorization of “barriers.” We also stress that if the FP community is to meet demand for FP, we must improve FP access for both users and non-users alike, hence our incorporation of “continuation” in our access definition. To wit, women, girls, and couples who are using contraception may be doing so in spite of barriers. Their experience of barriers contributes to contraceptive discontinuation and unmet need.¹⁶ Data on access must therefore be collected from both FP users and non-users. To best direct our limited resources, we must identify which domains are precluding access and by what magnitude. The DHS provides some important information in this respect, but it is limited. These limitations are described herein, as are suggestions for filling data gaps.

As mentioned in the results section, the DHS provides data only on the client-level domains of access. As expected, information about provider and service delivery point domains of access is not collected through the DHS, since it is a household sample survey. Meanwhile, the DHS’s data on client-level domains are not especially robust. The three questions that we identified as related to ability to pay for services, for example, are only indirectly related to the domain (Table 2). Similarly, the question on whether a woman can ask her partner to use a condom that we identified as related to the psychological, attitudinal, and societal domain may have more to do with a given woman’s empowerment than her ability to access FP. Furthermore, the data collected through the one question that has been used most for understanding access—Q709 Can you tell me why you are not using a method to prevent pregnancy?—are fraught with selection bias and interpretation challenges.

Examining Q709 more closely, we observe that it is asked only to women who want to have a child 24 or more months in the future or want no (more) children and are not using contraception. It excludes women whose future fertility intentions are unclear, who do not declare a numeric timeframe for having their next child, who are currently pregnant, or who are current contraceptive users. Among these ineligible women are groups with potential unmet need (Table 4)—those who want a child after marriage, those who want a child but don’t know when, those who are undecided, and those who are currently pregnant with an unintended pregnancy—and the current question does not provide any information about them. Clearly, the women eligible to answer this question do not represent all women who experience access barriers. This selection bias impacts our ability to generalize responses to all women with unmet need, let alone women who are contraceptive users with access challenges. Especially important to acknowledge is underlying assumption not only of this question, but of the broader FP community, that current contraceptive users do not experience barriers to contraceptive uptake and continuation. Given the high level of contraceptive discontinuation among women who do not want to have a(nother) child ever or in the next 24 months, we know that access remains a challenge even among contraceptive users. Recent analyses show that contraceptive discontinuers account for 38 percent of all women with unmet need.¹⁷

Setting aside the selection bias and access assumption problems, interpretation of answers provided to Q709 is also a challenge. Let’s consider some common responses provided—“not married”, “postpartum amenorrhea”, “breastfeeding”, and “side effects/health concerns”. “Not married” as a reason for not using contraception is provided by 24 percent of respondents in Zimbabwe and 13.6

¹⁶ Jain AK, Obare F, RamaRao S, Askew I. Reducing unmet need by supporting women with met need. *Int Perspect Sex Reprod Health*. 2013 Sep;39(3):133-41.

¹⁷ *Ibid.*

percent of respondents in Ethiopia. It could imply a client-level barrier— the woman believes that regular use of contraception is only for married couples, a provider-level barrier— the provider refuses to provide contraception to an unmarried women because of his/her bias against premarital sex. It could be a service-level barrier—policy prohibits services for unmarried women. Without understanding this response, it is impossible to draw effective policy or programmatic conclusions.

Another common reason provided is “postpartum amenorrhea”, identified by 25.5 percent of respondents in Rwanda and 20.1 percent in Ethiopia. Most likely, this response reveals a client-level barrier of incorrect knowledge of fertility return, but it could also reflect a subset of women who are legitimately not at risk of pregnancy either because they meet lactational amenorrhea method criteria or because they are not currently sexually active. Similarly, “breastfeeding” was identified as a reason by 10.6 percent of women in Ethiopia and 22.7 percent of women in Senegal. This reason for not using contraception could be related to a woman’s understanding of fertility return, her concern for hormonal contraception’s impact on milk production and/or milk quality, or both. Additionally, “side effects/health concerns” are cited by a large percentage of women across all four countries. Unfortunately, we do not know whether these concerns pertain to experienced side effects, potential and real side effects, or myths. The programmatic response to each of these pieces would differ greatly depending on the answer.

Finally, in exploring reasons provided to Q709, it’s interesting to note that only a small percentage of the reasons provided relate to contraceptive availability or cost. This finding spans not only these four countries, but also these regions: sub-Saharan Africa, Southeast Asia, and South Central Asia, as explored in other related research.^{18,19} Unfortunately, the omission of availability and cost factors from reasons cited cannot be taken on face value as an indication that FP availability and cost are not barriers. Rather, the omission could be a function of where these respondents are in terms of behavior change and adoption of FP. Specifically, client-level barriers related to information, attitudes, and agency, must be overcome before a given woman would even encounter FP availability and cost barriers. This omission also speaks to the need to examine which women are responding based on eligibility criteria, and to consider how these women differ from other women. For example, FP availability and cost barriers may be experienced by a higher proportion of current users compared to non-users.

We recommend the following steps be taken to improve data on FP access: 1) revise the DHS core questionnaire in a few key ways, described herein; 2) utilize household and facility-based data from non-DHS data sources; and 3) conduct qualitative research to explore access more deeply. With regard to our first recommendation, we believe that improvements can be made to the DHS questionnaire. Response categories to Q709 can be further honed with additional probes following reasons that are vague, like “not married” or “breastfeeding”. The eligibility criteria for Q709 can also be expanded to include all women with potential unmet need for contraception, such as women who do not know their future fertility intentions and those who do not specify when they want to have their (next) child but who are not using contraception. Elimination of the question could be considered as well, since selection bias and incorrect interpretation of data can mislead policy development and the quantitative

¹⁸ Darroch JE, Sedgh G and Ball H, *Contraceptive Technologies: Responding to Women’s Needs*, New York: Guttmacher Institute, 2011.

¹⁹ Chowdhury, Sadia; Vergeer, Petra; Schmidt, Harald; Barroy, Helene; Bishai, David; Halpern, Scott. 2013. *Economics and ethics of results-based financing for family planning: evidence and policy implications*. Health, Nutrition, and Population (HNP) discussion paper. Washington DC ; World Bank Group.

survey is not well designed to answer qualitative “why” type questions. We also recommend adding a few questions to the women’s core questionnaire that would be directed to current FP users to assess whether they experience barriers to contraceptive uptake and continuation. For example, questions to current users could ask whether she has experienced any challenges using her current method and if yes, what those challenges are. Other potential questionnaire modifications could allow for further exploration the side effect concerns of users and non-users. Questions to FP non-users could ask, “Are you worried about side effects?” and if yes, “What are the side effects that you’re worried about?”. While questions to current and ever users could ask, “Have you experienced side effects? ” and if yes, “What were they?”. Collecting this additional information will provide the data backbone to drive improved FP policies and programming, as well as the development of new contraceptive technologies.

With regard to our second recommendation, it is imperative that data be collected and analyzed on the service delivery point and provider-level domains of access. Service Provision Assessments (SPA) could fill this data gap as SPA provide key data on availability of contraceptives and supplies, user fees, quality of counseling, and client satisfaction.²⁰ Unfortunately, over the last five years SPA data is available for only a handful of countries—Namibia (2009), Kenya (2010), Senegal (2012), and Haiti (2013). Though Bangladesh, Ethiopia, Malawi, and Tanzania will complete a SPA in the coming year, these additional data will not come close to meeting the gaping information need. Another growing data source is PMA2020, which has the primary aim of “collect[ing] a nationally representative sample of data from households and service delivery points in selected sentinel sites, to estimate family planning and key water and sanitation and health indicators on an annual basis in ten pledging FP2020 countries.”²¹ PMA2020 provides data not currently available through the DHS on the client-level domains of FP access, including information on whether the respondent received the contraceptive method that she wanted (Q38), if not, why not (Q39), who made the final decision about the method she received (Q40), whether she return to that provider (Q41), and whether she would refer her friend or relative to that provider (Q42).²² Akin to the SPA, but with a different methodology and a primary focus on FP service provision, PMA2020 also provides service provision point data necessary for understand provider and service delivery point access domains. As of writing, data only from Ghana are available in the form of a two-page fact sheet. It is expected that indicators from Burkina Faso, Democratic Republic of Congo, Ethiopia, Kenya, and Uganda will be available in the 2014-2015 timeframe. Though these data will help to improve our understanding of FP access, the information gap remains wide. Additional investment in data collection that would allow for improved assessment of provider and service delivery point access domains is crucial.

Third, quantitative data will only get us so far. To improve and expand access, we must invest in qualitative studies. Ideally, the FP community could coordinate qualitative research protocols across a number of countries and communities within those countries to deeply understand access and use this information to drive policies and programming at scale. Such data are imperative for best directing limited resources toward improving and expanding access, and meeting demand.

CONCLUSION

In order to drive improved policies and programming to improve FP access and meet demand for FP, we must address barriers to contraceptive uptake and continuation. To expand and improve FP access, we

²⁰ More detail on SPA can be found here: <http://dhsprogram.com/What-We-Do/Survey-Types/SPA.cfm>

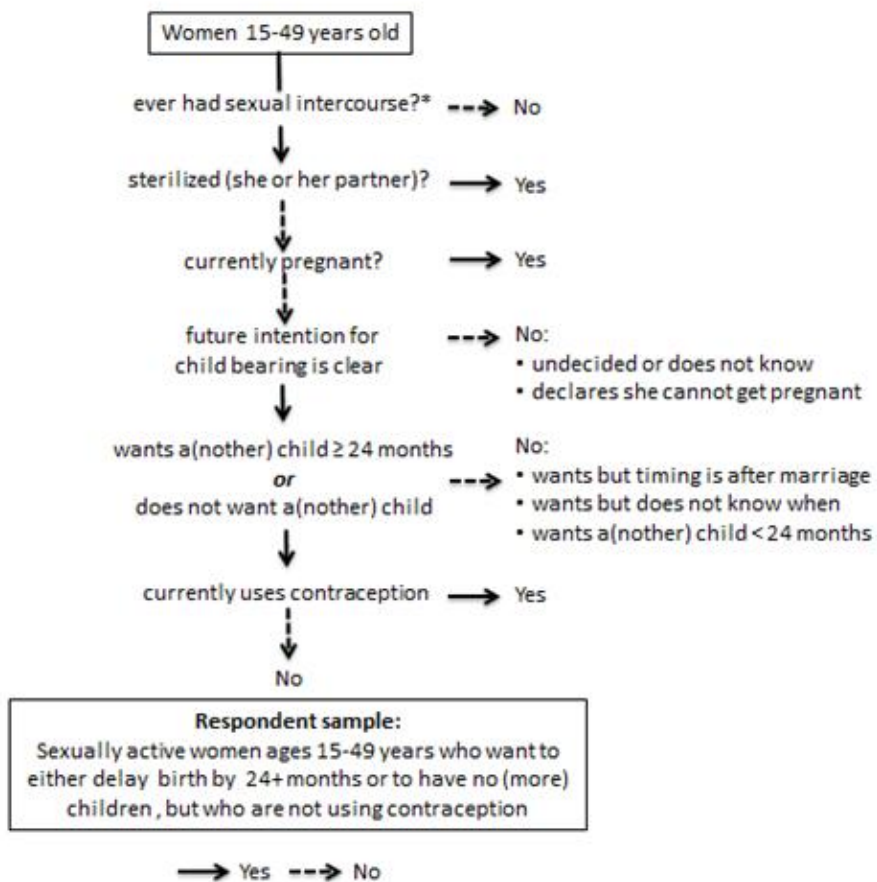
²¹ For more information on PMA2020, see <http://www.pma2020.org/methodology>. Accessed April 16, 2014.

²² PMA2020. Female Respondent Questionnaire. Web. Accessed April 16, 2014. <

http://www.pma2020.org/sites/default/files/questionnaires/Female%20Respondent%20Survey_Ghana.pdf>

must have a common framework for measuring the scope and magnitude of barriers, high quality and standardized tools to collect necessary data, and a policy and programmatic approach that uses these data to address identified needs. The FP community must also recognize that FP access is of concern to both FP users and non-users, and examine access-related data from both groups. The DHS presents a reliable and sensible platform for advancing data collection related to client-level domains of FP access. It can be further improved. Moreover, the FP community should invest in other data collection avenues, including PMA2020, facility assessments such as SPA, and qualitative studies, to fill information gaps. Though our study begins to make the concept of access more tangible, measurable, and meaningful, work remains.

Figure 1. Skip pattern and the denominator for Q709, reasons for not using contraception



*Not part of the questionnaire skip pattern, not included in analysis.

Table 1. Select fertility and family planning indicators for the four study countries.

	Senegal	Ethiopia	Rwanda	Zimbabwe
	2010	2011	2010	2010-11
Contraceptive prevalence rate (%)*	13.1	28.6	51.6	58.5
Modern contraceptive prevalence rate (%)*	12.1	27.3	45.1	57.3
Unmet need for family planning (%)*	30.1	26.3	20.8	14.6
Demand for FP satisfied with modern methods	28.0	49.7	62.3	78.4
Survey sample size (women 15-49 years)	16,515	9,171	13,671	15,688

*Among married women (Source: www.STATcompiler.com)

Table 2. DHS Access-Related Questions

Client Domains of FP Access* Clients must:	DHS Questions Women's Core Questionnaire, Phase 6	
Be unconstrained from psychological, attitudinal, or social factors in seeking FP services	<ul style="list-style-type: none"> o Q631: If you wanted to, could you yourself get a condom? o Q634: If you wanted to, could you yourself get a female condom? o Q718: Would you say that using contraception is mainly your decision, mainly your (husband's/partner's) decision, or did you both decide together? o Q950: Could you ask your (husband/partner) to use a condom if you wanted him to? 	<p>Applicable to all four client domains:</p> <ul style="list-style-type: none"> o Q709: Can you tell me why you are not using a method to prevent pregnancy? o W59. CALENDAR—Can you tell me why you discontinued using a method to prevent pregnancy?
Have correct, appropriate information to locate services, choose whether to use FP, and choose which method to use	<ul style="list-style-type: none"> o Q301: Have you ever heard of (METHOD)? o Q312: Were you ever told by a health or family planning worker about other methods of family planning that you could use? o Q317: At that time, were you told about side effects or problems you might have with the method? o Q317A: When you got sterilized, were you told about side effects or problems you might have with the method? o Q318: Were you ever told by a health or family planning worker about side effects or problems you might have with the method? o Q319: Were you told what to do if you experienced side effects or problems? o Q324: Do you know of a place where you can obtain a method of family planning? o Q325: Where is that? (place to obtain a method of family planning) o Q326: In the last 12 months, were you visited by a fieldworker who talked to you about family planning? o Q328: Did any staff member at the health facility speak to you about family planning methods? o Q632: Do you know of a place where a person can get female condoms? o Q633: Where is that? (place to get female condoms) o Q714: In the last few months have you: Heard about family planning on the radio? Seen anything about family planning on the television? Read about family planning in a newspaper or magazine? 	
Have the ability to pay for reaching the service/supply and obtaining the service/supply	<ul style="list-style-type: none"> o Q817: Who usually decides how the money you earn will be used: you, your (husband/partner), or you and your (husband/partner) jointly ? o Q819: Who usually decides how your (husband's/partner's) earnings will be used: you, your (husband/partner), or you and your (husband/partner) jointly? o Q1009: Are you covered by any health insurance? 	
Have comfort interacting with the provider	N/A	
*Note: DHS does not capture data on provider or service delivery point domains of FP access.		

Table 3. Response Categories—Q311. Why did you stop using the (Method)? and Q709. Can you tell me why you are not using a method to prevent pregnancy? Any other reason?

<p>Common to Q311 and Q709</p>	<ul style="list-style-type: none"> • infrequent sex* • menopausal/hysterectomy • cant' get pregnant/difficult to get pregnant** • husband/partner opposed*** • up to God/fatalistic • side effects/health concerns • lack of access/too far • costs too much • inconvenient to use • other • don't know <p><i>Compared with Q709,</i> <i>*Q311 lumps "husband away" with "infrequent sex" response</i> <i>**Q311 lumps "difficult to get pregnant" with "menopausal" response</i> <i>***Q311 replaces "opposed" with "disapproved"</i></p>
<p>Unique to Q311</p>	<ul style="list-style-type: none"> • became pregnant while using • wanted to become pregnant • wanted more effective method • marital dissolution/separation
<p>Unique to Q709</p>	<ul style="list-style-type: none"> • not married • not having sex • not menstruated since last birth • breastfeeding • respondent opposed • others opposed • religious prohibition • knows no method • knows no source • preferred method not available • no method available • interferes with body's normal processes

Table 4. Eligibility screening for Q709, reasons for not using contraception

	Zimbabwe		Rwanda		Ethiopia		Senegal	
	2010-11		2010		2011		2010	
	n	%	n	%	n	%	n	%
Total	9,171	100.0	13,671	100.0	16,515	100.0	15,688	100.0
Ineligible because she:								
She never had sex	1,662	18.1	4,142	30.0	3,957	25.2	3,629	26.1
She or her partner is sterilized	85	0.9	68	0.5	49	0.4	27	0.2
She is currently pregnant	723	8.3	937	7.0	1277	7.3	1297	7.7
When asked about future fertility intention,								
She is undecided or does not know about future fertility intention	372	4.3	145	1.1	373	2.2	207	1.3
She declares she cannot get pregnant	110	1.1	99	0.7	300	1.8	364	2.1
She wants a/another child in the next 24 months	1162	13.0	683	5.0	2363	11.5	2989	18.3
She wants a/another child after marriage	101	1.2	595	4.2	194	1.0	923	5.8
She wants a/another child but does not know when	86	0.9	93	0.7	371	1.6	533	3.1
She uses a contraceptive method	2,989	32.4	3,579	26.2	2,362	16.0	903	6.7
Eligible for the question	1,881	19.9	3,330	24.7	5,269	33.0	4,816	28.8

All estimates were adjusted for sampling weights. All number of women are unweighted number.

Table 5. Background characteristics of respondents, women who meet eligibility criteria for Q704

	Zimbabwe		Rwanda		Ethiopia		Senegal	
	2010-11		2010		2011		2010	
	% total	% included in Q709	% total	% included in Q709	% total	% included in Q709	% total	% included in Q709
Residential area								
rural	61.3	21.4	85.0	25.2	76.1	36.7	50.7	35.4
urban	38.7	17.7	15.0	21.8	23.9	21.3	49.3	22.0
Education								
no education	2.3	43.2	15.5	44.4	50.8	45.1	57.9	37.4
some primary	28.0	25.1	68.3	22.9	38.0	22.4	21.8	23.0
some secondary	65.1	16.9	14.7	13.7	6.8	14.9	18.3	10.9
some higher than secondary	4.6	18.8	1.5	13.4	4.4	12.6	2.1	8.5
Union status								
in union	37.8	26.9	49.6	20.9	37.7	19.8	34.1	4.5
not in union	62.2	15.7	50.5	28.5	62.3	41.0	66.0	41.3
Group								
in union	62.2	15.7	50.5	28.5	62.3	41.0	66.0	41.3
single, sexually active, recent*	2.7	21.4	1.8	24.3	1.2	26.4	0.8	9.0
single, sexually active, ever	17.0	56.5	17.8	55.6	11.4	62.7	8.0	18.2
single, never had sex	18.1	0.0	30.0	0.0	25.1	0.0	25.3	0.0

*"sexually active, recent" refers to having had sexual intercourse in the last four weeks before the survey.

Table 6. Percent distribution by the number of reasons reported among the eligible women.

Number of reasons	Zimbabwe	Rwanda	Ethiopia	Senegal
	2010-11	2010	2011	2010
0	0.7	1.2	1.9	5.1
1	76.2	69.6	75.6	83.2
2	21.2	24.7	19.8	9.9
3	1.9	4.1	2.5	1.7
4	0.1	0.3	0.1	0.1
5	-	0.0	0.0	-
6	-	0.0	-	-
Mean number of reasons reported	1.25	1.33	1.23	1.09

Note: 0 includes women who reported “don’t know” or “missing”.

Table 7. Percent of eligible women who report each reason for not using contraception.

	Zimbabwe	Rwanda	Ethiopia	Senegal
	2010-11	2010	2011	2010
	Mean	Mean	Mean	Mean
Individual reasons reported				
not married	24.0	5.4	13.6	2.7
not having sex	40.1	25.6	12.0	8.0
infrequent sex	14.4	18.5	3.6	9.4
menopausal/hysterectomy	8.0	4.5	2.0	4.7
subfecund/infecund	3.5	1.0	2.3	1.2
postpartum amenorrhic	2.3	25.5	20.1	9.3
breastfeeding	6.4	6.7	10.6	22.7
fatalistic	2.4	6.0	9.7	4.0
respondent opposed	3.1	1.9	2.2	15.8
husband/partner opposed	3.0	2.0	4.1	9.0
others opposed	0.1	0.1	0.6	0.6
religious prohibition	3.5	1.0	6.1	2.6
knows no method	0.0	0.3	3.0	2.4
knows no source	0.3	0.1	3.2	2.0
fear of side effects/health concerns	5.8	10.5	15.2	9.3
lack of access/too far	0.7	0.0	1.7	0.8
costs too much	2.1	0.0	0.2	2.3
inconvenient to use	0.9	0.8	2.5	0.8
interferes with body's processes	0.7	2.6	3.5	1.0
preferred method not available	0.3	0.0	0.1	0.2
no method available	0.2	0.0	0.2	0.1
other	3.0	20.9	7.3	0.9
don't know	0.4	0.2	1.0	4.2
Further classified reasons*				
not at risk	62.8	47.5	19.3	22.6
opposed by other only	6.3	2.5	9.6	10.6
opposed by anyone	9.4	4.4	11.8	26.3
potential myth about postpartum fertility return	8.4	28.3	27.7	30.7
lack of knowledge	0.3	0.4	5.2	4.1
fear of side effects/health concerns	6.3	12.0	17.5	10.3
inconvenient	0.9	0.8	2.5	0.8
supply problem	3.1	0.0	2.1	3.3

*Definitions for aggregate reasons are as follows: Not at risk refers to: no sex, infrequent sex, menopause, or sub fecund; opposed by other only refers to: opposed by husband, other, or religion, but her own opposition is not reported; opposed by any refers to opposed by other or herself; potential myth about postpartum fertility return refers to postpartum amenorrhea; lack of knowledge refers to: knows no method or knows no source; and supply problem refers to: lack of access/too far, costs too much, preferred method not available, or no method available.

Table 8. Contraception use status by exclusion type

	Zimbabwe 2010-11		Rwanda 2010		Ethiopia 2011		Senegal 2010	
	n	% using contraception	n	% using contraception	n	% using contraception	n	% using contraception
Ineligible because she:								
She never had sex	1,662	0.0	4,142	0.0	3,957	0.1	3,629	0.1
She or her partner is sterilized	85	100.0	68	100.0	49	100.0	27	100.0
She is currently pregnant	723	0.0	937	0.0	1,277	0.0	1,297	0.0
When asked about future fertility intention,								
She is undecided or does not know about future fertility intention	372	59.2	145	46.7	373	21.5	207	8.4
She declares she cannot get pregnant	110	8.6	99	2.1	300	1.5	364	1.6
She wants a/another child in the next 24 months	1,162	35.4	683	20.0	2,363	20.0	2,989	6.0
She wants a/another child after marriage	101	19.3	595	6.7	194	11.2	923	13.4
She wants a/another child but does not know when	86	56.0	93	19.3	371	16.8	533	11.6
She uses a contraceptive method	2,989	100.0	3,579	100.0	2,362	100.0	903	100.0
Eligible for the question	1,881	0.0	3,330	0.0	5,269	0.0	4,816	0.0
TOTAL	9,171	41.2	13,671	28.6	16,515	19.5	15,688	9.3