



Photo credits: ©iStockphoto.com/Guenter Guni | ©iStockphoto.com/Steve Burger | Curt Camemark/World Bank



EQUITY

Understand Barriers to Access Among the Poor

There are many reasons why the poor are not able to access healthcare services in developing countries. The EQUITY Framework¹ calls for understanding these barriers to inform the development of appropriate responses at the policy and program levels. Barriers to equitable service access and use are often rooted in a variety of sources, including policy, financial, operational, and sociocultural issues (see Figure 1). Low access may result from lack of knowledge or information, lack of resources, and limited access to facilities that provide decent care, as well as unresponsive health providers and direct and indirect costs of services. Informal fees and other costs, such as healthcare supplies and medicines not provided by the facility, transportation, “under the table” payments, and food and board, in many cases constitute prohibitive costs resulting in poor families foregoing health services. Social health insurance, demand-side financing, community-based distribution of health-related commodities, and targeted use of resources are some of the strategies that have been tried by countries to improve access to resources and services among the poor.

Identification of barriers typically involves quantitative and qualitative analysis, adapted to the country, the information and data available, and the most

- E** - engage the poor
- Q** - quantify inequalities
- U** - understand barriers
- I** - integrate equity goals
- T** - target resources and efforts
- Y** - yield public-private partnerships

appropriate means for actively involving the poor in problem identification and dialogue. Through quantitative research—such as analyzing Demographic and Health Surveys (DHS), Service Provision Assessments (SPAs), and other sources of data—it is

possible to identify those groups with least access to services, as well as analyze reasons for discontinuation and nonuse of family planning. Through qualitative research, including focus group discussions (FGDs) and exit interviews, the poor can engage in identifying the problems that prevent them from accessing services. This information can form the basis of discussion and subsequent identification of strategies to eliminate or reduce barriers. Suggestions for possible strategies may emerge from open discussion of the analysis findings with communities, policymakers, and other stakeholders.

The USAID | Health Policy Initiative, Task Order 1, has assessed barriers to equitable access to family planning (FP), reproductive health (RH), and/or HIV services for the urban and rural poor (e.g., Kenya, India), indigenous populations (e.g., Guatemala, Peru), HIV-positive women (e.g., Kenya, Tanzania), orphans and vulnerable children (e.g., Botswana, Democratic Republic of Congo), and survivors in conflict-affected countries (e.g., Sierra Leone). This brief focuses on



two examples to highlight barriers faced by the poor. In Kenya, barriers analyses and policy dialogue involving the poor informed the development of the *National Reproductive Health Strategy* to improve access among the poor.² In Guatemala, the project researched barriers to access to FP/RH among indigenous women and assisted with development and testing of strategies and technical guidelines to address the barriers.³

Barriers to FP Access Among the Poor in Kenya

In Kenya, the Health Policy Initiative assisted the government to involve the poor in identifying barriers to FP access and use. The project began by reviewing the 2003 Kenya DHS and 2004 Kenya SPA, which provide information on reasons for discontinuation, reasons for not intending to use family planning in the future, service/method availability, and service quality. To explore the barriers faced specifically by the poor, in mid-2008, the project conducted a rapid assessment in urban and rural areas. The assessment focused on Nyanza Province, chosen due to its poverty level, low contraceptive prevalence, and high unmet FP need. The project conducted 33 FGDs (with 10–15 participants each) with members of urban and rural poor populations. Participants included women under age 30, both FP users and non-users; women over age 30, both users and non-users; and men. The project also interviewed 23 FP service providers and conducted short exit interviews with 154 clients to gather information on fees for services.

Misinformation and Misconceptions

Despite a high awareness of some FP methods, the FGD participants and FP providers noted common misconceptions about the use of family planning. These

myths and misconceptions typically related to potential side effects, such as pain, infertility, or birth defects. In some cases, such beliefs were based on personal experiences, but most often were based on reports from relatives or community members.

“People say that users can deliver babies with two heads, and some report continuous headaches and backaches which make a woman unable to work, such as plowing the land, working in the shamba. This is the reason why I have not used, because I have to do a lot of hard work to feed my children.”

(Female, rural area)

Sociocultural Barriers

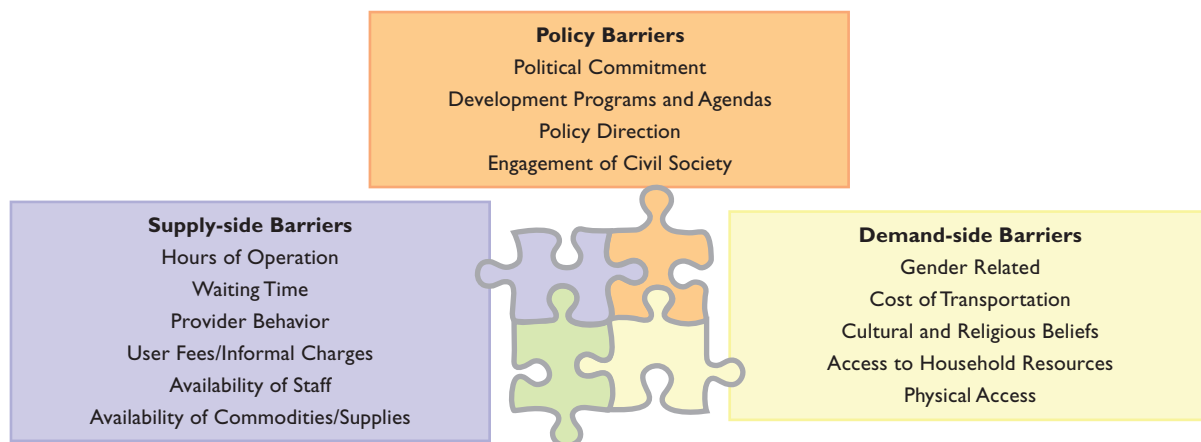
There is limited communication about family planning between spouses. Plus, spousal opposition was one of the key barriers mentioned in all the discussions. According to female and male discussants, men oppose FP use because they think women will become promiscuous. Women who use family planning might also be seen as challenging men’s authority.

“Many [men] are influenced by the peers who do not understand the need for family planning. They think that when their wives use contraceptives, they will no longer be able to have children. Some tend to think that having many children will enable them to become wealthy. Some people want to have children of both sexes, particularly when they only have girls.”

(FP provider)

Preferences for large families and for sons are deeply held beliefs among community members. For some men, there is a competition to have larger families as this is believed to be a sign of strength and virility of the man and of the family’s wealth. Women report that mothers-in law support the belief

FIGURE I: UNDERSTANDING BARRIERS TO ACCESS



Low Access Among the Poor

that wives are meant to bear children for their sons. Women also said that having many children, especially sons, is a way to ensure their position within the family and keep husbands from taking on additional wives.

“When you have children, a man can no longer threaten you.”

(Female, rural area)

Costs and Frequent Stockouts

Costs for services include travel costs, lost wages or lost time for non-wage earners, costs for child care, and fees for services. The distances to health facilities are particularly prohibitive to residents of rural areas.

“Because to go to the health post is so far, we don’t have money to go. Women also do not have time to go.”

(Female, rural area)

When commodities stockouts are frequent, costs become even more burdensome for poor women. Women reported frustration at having to pay travel costs, lose wages, plead with neighbors to watch their children, and/or take time away from their daily chores, only to reach the facility and learn that the FP commodities or other needed supplies are unavailable.

Participants also reported having to pay fees for services. According to Kenyan government policy, FP services in government facilities are to be provided for free, as are government-supplied FP commodities distributed by private and nongovernmental organization (NGO) providers. However, clients might have to pay registration costs, fees for medical tests, and, in some cases, fees for commodities and other hidden fees, which are not uniform across providers or even within the same facility.

Similarly, client exit interviews revealed that public, faith-based, and NGO facilities all charge for FP methods and commodities. Out of the 154 clients interviewed, 94 (61%) had paid for the FP services, including 76 people who had accessed government facilities, which are supposed to offer free services.

Provider Behavior

Some discussants reported poor provider-client interactions, including limited counseling on FP options and side effects and use of condescending language. Providers also reported being overwhelmed by staff shortages and heavy workloads. In such cases, a provider noted, it is easier to provide the method the client asks for than to initiate a full counseling session. Even so, discussants in urban areas mentioned generally having good provider-client interactions.

To learn how Kenya addressed these barriers in the National RH Strategy, please see the EQUITY brief on integrating equity goals, approaches, and indicators into policies, plans, and development agendas.⁴

Barriers to Access to FP/RH Services among Indigenous Women in Guatemala

In Guatemala, barriers analysis included interviews with indigenous women and healthcare providers in three departments (*departamentos*) with large indigenous populations—Quiché, Sololá, and Totonicapán. The Health Policy Initiative conducted 33 group interviews:

- Eight group interviews with 69 indigenous women users of modern FP methods who obtain services from the Ministry of Public Health and Social Welfare (MSPAS) or APROFAM (Association for the Wellbeing of the Family)
- 14 group interviews with 99 indigenous women not using any FP method, separated into those who either obtain or do not obtain health services for their families
- 11 group interviews with 69 community health educators and traditional midwives

The project also conducted interviews with 108 service providers, including doctors, nurses, auxiliary nurses, and community educators (51 in Quiché, 31 in Sololá, and 26 in Totonicapán) in MSPAS, IGSS (Guatemalan Social Security Institute), and APROFAM facilities.

Provider Bias toward Indigenous Women

Many indigenous women who participated in the group interviews reported that providers discriminated against them and treated them badly because of their ethnicity and inability to speak Spanish fluently. As a result, indigenous women do not feel comfortable with the providers and lack confidence in the services and information they provide.

Providers expressed difficulties assisting indigenous women. Half of the 108 service providers interviewed said that they doubted that indigenous women have the capacity to understand information regarding FP services. The providers also stated that they have difficulty finding words and terms that are culturally-appropriate for indigenous women.

Furthermore, some providers expressed negative perceptions of indigenous women and indigenous society. For example, in Totonicapán, a provider stated that indigenous women are very traditional and are dedicated only to homemaking and having children.

Unsuitable Conditions in Facilities

Providers and indigenous women reported that the lack of privacy and inability to communicate hampered service delivery, as did long wait times and inconvenient facility hours. The physical environment of some health clinics—e.g., lack of private areas for consultation—contribute to the reluctance of indigenous women to seek services. Without privacy or confidentiality, many indigenous women hesitate to inquire about contraceptive methods or ask questions.

Restrictive Social and Familial Environments

Indigenous women face community and familial pressure to not use family planning. Many community members believe that women who use FP methods will be unfaithful to their spouses and are not fulfilling their marital and familial role to bear children. Consequently, indigenous women fear rejection or ostracism by their community. Indigenous culture is also influenced by the opinion of community elders and religious beliefs, limiting the autonomy of women to make decisions about family planning. In about one-third of the groups, indigenous women said that women do not use FP methods because of the opposition by community elders. Mothers and mothers-in-law think that using FP methods goes against the customs and traditions of the community. In a majority of groups, women mentioned spousal opposition as a restrictive factor.

Lack of Appropriate Information Materials

FP materials available to clients are not culturally appropriate (e.g., they feature non-indigenous women or are in Spanish); do not address the myths about FP that are prevalent in communities; and do not explain the side effects of contraceptive methods.

Limited Integration of Community-based Providers in the Community

The community facilitators and health promoters work closely with the community and are supervised by MSPAS personnel. By design, the community facilitators and health

promoters should be key actors in the promotion of FP within their communities. However, respondents stated that the participation of community facilitators and promoters was limited and not integrated into the community.

To learn how Guatemala addressed these barriers through technical guidelines and norms, please see the EQUITY brief on targeting resources and efforts to the poor.⁶

Conclusion

A combination of quantitative and qualitative analyses can help to identify the poor and explore the challenges they face. Involving the poor in identifying barriers to services and designing appropriate policy responses is a vital step toward reducing inequities in healthcare access and use. It is important to gather viewpoints from users and non-users of services as well as providers to understand why underserved populations are not using services. Based on the findings, a key next step is to support policy dialogue to develop interventions to improve access to healthcare for underserved groups.

The USAID | Health Policy Initiative, Task Order 1, is funded by the U.S. Agency for International Development under contract GPO-I-01-05-00040-00, beginning September 30, 2005. Task Order 1 is implemented by Futures Group, in collaboration with the Centre for Development and Population Activities (CEDPA), White Ribbon Alliance for Safe Motherhood (WRA), and Futures Institute. To learn more, please contact:

Futures Group
Health Policy Initiative
One Thomas Circle, NW, Suite 200
Washington, DC 20005 USA
Tel: (202) 775-9680
Email: policyinfo@futuresgroup.com
Web: www.healthpolicyinitiative.com

ENDNOTES

- ¹ Health Policy Initiative, Task Order 1. 2010. "EQUITY Framework for Health." Washington, DC: Futures Group, Health Policy Initiative, Task Order 1.
- ² Health Policy Initiative, Task Order 1. 2010. *The EQUITY Framework: Influencing Policy and Financing Reforms to Increase Family Planning Access for the Poor in Kenya*. Washington, DC: Futures Group, Health Policy Initiative, Task Order 1.
- ³ Netzer, Sara and Liz Mallas. 2008. *Increasing Access to Family Planning among Indigenous Groups in Guatemala*. Washington, DC: Futures Group, Health Policy Initiative, Task Order 1.
- ⁴ Health Policy Initiative, Task Order 1. 2010. "EQUITY: Integrate Equity Goals, Approaches, and Indicators into Policies, Plans, and Development Agendas." Washington, DC: Futures Group, Health Policy Initiative, Task Order 1.
- ⁵ *Departamentos* are administrative districts similar to states in the United States.
- ⁶ Health Policy Initiative, Task Order 1. 2010. "EQUITY: Target Resources and Efforts to the Poor." Washington, DC: Futures Group, Health Policy Initiative, Task Order 1.