

Part II.H.1

Access

- Average time/distance to the nearest reproductive health facility offering a specific service
- Number of service facilities offering a specific RH service per 500,000 people
- Cost of one month's supply of contraceptives as a percent of monthly wages
- Percent of facilities with non-medical restrictive eligibility criteria
- Percent of non-use related to psycho-social barriers

A primary strategy of health programs is to increase access to services. Different approaches to increasing access include establishing additional facilities, training more health workers, increasing outreach activities, and so forth. Despite the widely acknowledged importance of access as a key feature of the supply environment, this factor is not routinely assessed in RH program evaluation.

Much of the previous research in this area has focused on one aspect or dimension of accessibility: geographic (or physical) access. In this context, access (or accessibility) refers to the degree of difficulty in reaching or obtaining reproductive health services. A variety of measures pertaining to the distance to supply and to service points, the time required to reach these points, and the density of service/supply points within a specified geographic area have been proposed in the literature (Chavoyan, Hermalin, and Knodel, 1984; Hermalin and Entwisle, 1985 and 1988; Tsui et al., 1992; Tsui and Ochoa, 1992). In the case of family planning, the evidence to date tends to confirm the relevance of geographic proximity to contraceptive services as an important determinant of contraceptive use; however, the

strength of the relationship between proximity and use in empirical studies has not been as strong as might be anticipated (Tsui and Ochoa, 1992; Boulier, 1985).

Some researchers have distinguished between the terms “availability” (to describe whether a particular method or service is provided) and “accessibility” (to denote a continuum of effort required to obtain services) [Bertrand et al., 1995]. However, the terms are often used interchangeably, and in this *Compendium* we use the word access to reflect the degree of difficulty (or ease) in accessing services.

Access to services is not merely an issue of physical distance, but one that involves other dimensions as well (Chavoyan, Hermalin, and Knodel, 1984; Foreit et al., 1978). Foreit et al. suggested the following as relevant dimensions or elements of accessibility (the authors used the term “availability” in the original text): geographic or physical, economic, administrative, and cognitive. The indicators that follow measure access along multiple dimensions: geographical/ physical (with two separate indicators), economic, administrative, and psychosocial.

Indicator

AVERAGE TIME/DISTANCE TO THE NEAREST REPRODUCTIVE HEALTH FACILITY OFFERING A SPECIFIC SERVICE

Element: Geographical/physical access

Definition

The time (measured in minutes) or the distance (measured in kilometers or miles) from a respondent's place of residence to the nearest service delivery site offering a specific type of reproductive health service (e.g., antenatal care, voluntary counseling and testing, male sterilization)

Data Requirements

Information on the location of the respondent in relation to the service delivery point in question

To obtain aerial distances ("as the crow flies"), one may use a geographic positioning system (GPS). Alternatively, one can map the routes between a given community and an individual service delivery point and can (preferably) obtain measures of travel time and actual distance; these measures are superior to the self-reports of respondents or key informants.

Data Source(s)

Data from facility-based surveys analyzed in relation to data from household surveys (e.g., in the context of a DHS survey)

Purpose and Issues

Ideally, the researcher will determine the distance between the home of an average citizen in country X and the nearest facility providing a specific reproductive health service. In the past, researchers often relied on self-report of survey respondents or of community informants, both of which tended to be highly unreliable. In recent years, researchers have attempted to link the DHS household surveys with surveys of the facilities

in the surrounding area in selected countries. In linking the data from the household and facility-based surveys, researchers and evaluators are, for the first time, able to accurately measure distance between these communities and service delivery points (Akin et al., 1998; Seiber and Bertrand, 2001).

There are, however, several caveats to measuring access using this linking technique. First, many DHS household surveys do not include a facility-based survey, or the facility-based survey is not linked to the household survey. Second, the human and financial resources needed to carry out a DHS with both the household and the facility-based components are considerable. Thus, in the best of cases, the linked surveys are conducted only once every 3-5 years. Third, this linking of the two surveys allows for a much more precise measurement of the time and distance between the household of the average respondent and the nearest service delivery point. However, research has shown that clients often elect to use services at some more distant point to preserve their privacy; to obtain a range of services (e.g., specific contraceptive method, or special lab procedures) not available at a facility closer to their home; or to obtain higher quality services (e.g., better client-provider communication).

To date, evaluators have studied physical access as a determinant of service utilization and use, but program managers have not routinely used it for the day-to-day monitoring of program performance, because of the time and expense associated with the above-mentioned linking procedure.

Gender Implications of this Indicator

Distance to the nearest reproductive health facility represents, on one hand, the commitment and resources of government to provide universal access to health care. It is an important variable to consider in terms of women's ability to obtain obstetrical services – maternal and child health care and family planning – particularly in areas where transportation is difficult. Distance to needed obstetrical services and lack of transport to reach a facility offering such services are key variables contributing to maternal deaths. Advocates for safe motherhood argue that these preventable deaths indicate that policy makers undervalue women's lives. Advocates employ human rights conventions to hold governments accountable for providing appropriate and accessible health services (Rosenfield, 2001). On the other hand, when women travel outside of their communities to obtain care at a remote service site, they may do so because some service facilities fail to adequately observe privacy and confidentiality, and women fear the consequences. For example, women who feel they must obtain contraceptives covertly because of perceived disapproval on the part of the husband or extended family may fear retribution if confidentiality is violated. Many small local service outlets have no potential for offering women visual privacy as they wait in line for services. However, even these facilities can observe policies and procedures to protect the woman's confidentiality in reproductive health choices and services obtained.

Indicator

NUMBER OF SERVICE FACILITIES OFFERING A SPECIFIC RH SERVICE PER 500,000 PEOPLE

Element: Geographical/physical access

Definition

The density of service facilities in a given population

Data Requirements

Information on the total number of facilities offering a specific service (e.g., contraceptives, postabortion care, voluntary counseling and testing, micronutrient supplementation) and the total population (or relevant subgroup) in the catchment area

Note: evaluators may limit the denominator to an estimate of the relevant sub-group for the service (e.g., all women of reproductive age for family planning, all pregnant women needing micronutrient supplementation, all adults 15 to 65 for HIV counseling and testing). Because of the difficulties associated with estimating the exact number of persons in need of such a service (e.g., postabortion care), evaluators may opt to use the total population in the denominator.

Data Source(s)

Program records on the service delivery infrastructure; census data on size of population in the catchment area

Purpose and Issues

This indicator gives a broad sense of the density of service delivery points for specific types of reproductive health interventions. It can be useful for advocacy purposes in creating awareness of the deficiencies in the service delivery environment for particular services.

Caveats for this indicator include the following. First, although this indicator gives a ratio of service delivery points per population, it does not reflect the geographical distribution of such points. In the case where ser-

vice delivery facilities cluster in urban areas, this indicator may yield a more favorable estimate of access to services than individuals in rural areas actually experience. Second, it is easier to collect information on the availability of some services than of others. For example, many countries have fairly accurate lists of family planning services through government or NGO facilities. However, they may not track the number of pharmacies that carry contraception and other reproductive health products, and thus may underestimate the access of the population to these commodities. In more controversial subject areas, such as postabortion care, facilities may provide services but not publicize them widely, and thus may create undercounts on this indicator for those services. A third caveat is that services may exist “on paper” but not at the actual field site.

One potential use of this indicator is to help governments track progress in terms of improving the service delivery environment for the population. However crude this measure is (and how little it reflects the situation of a specific individual in that society), it does represent progress for a government to increase the number of reproductive health facilities per 500,000 in the population (assuming quality remains constant or improves). Moreover, where data on the health service environment are fairly reliable, evaluators may collect this information at relatively little cost to the user.

Indicator

COST OF ONE MONTH'S SUPPLY OF CONTRACEPTIVES AS A PERCENT OF MONTHLY WAGES

Element: Economic access

Definition

“Costs” refer to out-of-pocket expenses for contraceptive supplies and services

This indicator is calculated as:

$$\frac{\text{Cost of one month's supply of contraceptives}}{\text{One month's wages}} \times 100$$

Data Requirements

Information on monthly expenditures on contraceptive supplies and services and estimated monthly income

Data Source(s)

Information from population-based surveys on service and supply costs; fees may also be available from facility records.

Purpose and Issues

This indicator provides a measure of the relative economic burden represented by monthly service and supply costs of contraceptive use. This measure applies specifically to family planning, but evaluators can adapt it to other areas of reproductive health by substituting the cost of the product in question for contraceptives in this definition.

Service and supply costs exceeding one percent of monthly wages for a significant proportion of clients may constitute an economic barrier to contraceptive use (Ross et al., 1992).

The illustrative indicator for this element was chosen from among several alternatives in large part because the data required for its computation are the most likely among the alternatives to be available in a reasonably

large number of developing country settings. However, evaluators should recognize that the indicator suffers from several important limitations.

One limitation is that the indicator ignores other costs of contraceptive use that may be just as, or perhaps more, important barriers to contraceptive use than direct service or supply costs are. For example, family planning clients may also incur out-of-pocket expenses for transportation to and from the facility and (possibly) for child care, as well as opportunity costs of time spent traveling to and from the SDP and waiting for service or supplies once clients reach the facility. Thus, a more valid measure of the costs of family planning services would also include these costs in the computation of the indicator.

Another issue concerns the stream of income that evaluators should consider in computing the indicator. Since not all income (gross income) is likely to be available for use in paying for contraceptive services, a more appropriate specification of the indicator will limit the denominator of the measure to monthly disposable income. Furthermore, since men and women do not have equal access to household financial resources in many societies, a further refinement may be to limit the denominator of the measure to income or wages controlled by the client (especially female clients).

Evaluators should recognize, however, that these refinements add to the data requirements for computing the indicator. In many countries, the required information may be available only from special studies. For most practical purposes, the simpler indicator should suffice to guide program management decisions regarding the affordability of contraceptive services. In programs where cost recovery and sustainability are priority management issues, however, the added costs of gathering data required for the more refined measures may be justified.

Indicator

PERCENT OF FACILITIES WITH NON-MEDICAL RESTRICTIVE ELIGIBILITY CRITERIA

Element: Administrative access

Definition

Eligibility criteria of a non-medical nature, mandated by the service facility or organization, which limit access to RH services for specific categories of individuals

This indicator is calculated as:

$$\frac{\text{\# of facilities with non-medical restrictive eligibility criteria}}{\text{Total \# of medical facilities}} \times 100$$

Data Requirements

Eligibility criteria for services offered by the program

Data Source(s)

Program documents outlining policies and regulations; interviews with staff

Purpose and Issues

This indicator identifies the existence of barriers to services in the form of unnecessary formal program policies, regulations, and procedures; such restrictions, mandated at the policy/program level, exceed those justified on medical grounds. Typical restrictive criteria for different reproductive health services include the following:

Family Planning:

- Age, parity, marital status, and/or spousal consent;
- Requirements for blood tests or pelvic examinations prior to the distribution of oral contraceptives;
- Requirements for multiple visits to receive certain contraceptive methods (e.g., IUDs);
- Requirements of direct physician involvement in the provision of services; and
- A required waiting period of several days between counseling for voluntary surgical contraception and the actual procedure.

STIs:

- Age, marital status, spousal consent;
- Partner notification; and
- Waiting period for HIV test results.

Maternal Health:

- Age, parity, marital status, spousal consent; and
- Requirements for direct physician involvement in provision of services (when other appropriately trained clinical staff [e.g., midwives] could provide the same service).

Adolescent Reproductive Health Services:

- Age, marital status; and
- Parental notification or consent.

Postabortion care:

- Parental or spousal consent prior to treatment;
- Inappropriate judicial requirements (e.g., rape may be a legal indication for elective abortion, and women are not permitted to obtain the service without “proof” of the rape, which might be a court order);
- Provision of uterine evacuation for incomplete abortion only in an operative theatre;
- Provision of uterine evacuation for incomplete abortion only under general anesthesia;
- Provision of uterine evacuation for incomplete abortion only by a physician;
- Inappropriate clinical criteria for use of manual vacuum aspiration for treatment of incomplete abortion; and
- Inappropriate criteria for contraceptive method provision following treatment of incomplete abortion.

Administrative barriers to access occur less frequently for STI/HIV services, which tend to be provided to those who seek treatment.

Indicator

PERCENT OF NON-USE RELATED TO PSYCHO-SOCIAL BARRIERS

Element: Psycho-social access

Definition

The proportion of women who want to use an RH service who avoid use because of barriers of a psycho-social nature; for example, fear (of negative social stigma, embarrassment, discomfort) or social restrictions (e.g., against women traveling alone to seek services)

This indicator focuses on factors that deter a woman or man who **wants** to use a certain service or practice from doing so. For example, adolescents wishing to obtain information and services from a local clinic might be deterred from doing so by fear of being seen at the clinic or being judged by friends to have low moral standards. A woman wanting to be tested for HIV might fear some type of violent reaction from her husband should he find out. Note: this indicator does not apply to the case where the individual is not even interested in the service.

This indicator is calculated as:

$$\frac{\text{\# who report non-use due to psycho-social barriers}}{\text{Total \# of clients seeking RH services}} \times 100$$

Data Requirements

Information on reasons for non-use of services or RH practices among individuals interested in but avoiding a particular service or practice

Data Source(s)

Population-based surveys; alternatively, focus group discussions (although they do not yield a quantitative result)

Purpose and Issues

This indicator provides a measure of the extent to which access to available RH services is limited by barriers of psychological, attitudinal, or social origin.

Given the context-specific nature of factors falling under this heading, the reasons for non-use of services will likely vary from setting to setting. Thus, the exact numerical figure associated with a particular barrier or factor may be less important than the rank ordering of problems. In view of this, data from focus groups (that do not provide results in quantitative terms such as percentages or ratios) may be more valuable in identifying barriers of this type than data derived from structured interviews are.