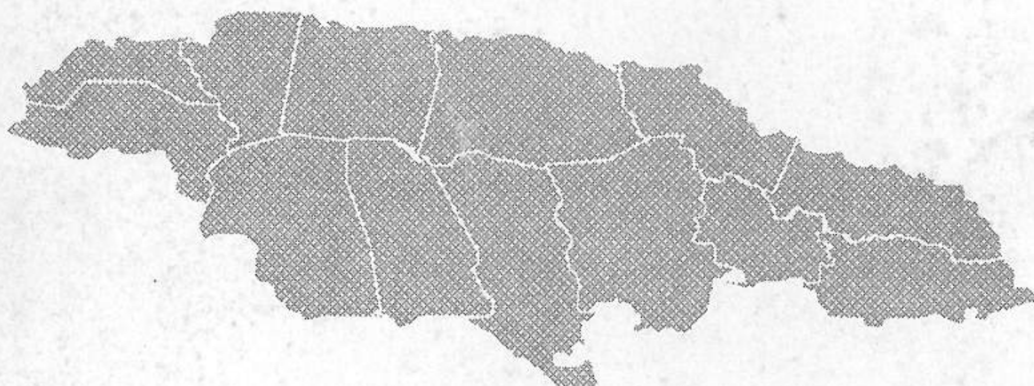
Family Planning Service Delivery Practices of Private Physicians in Jamaica

Final Report



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May, 1994

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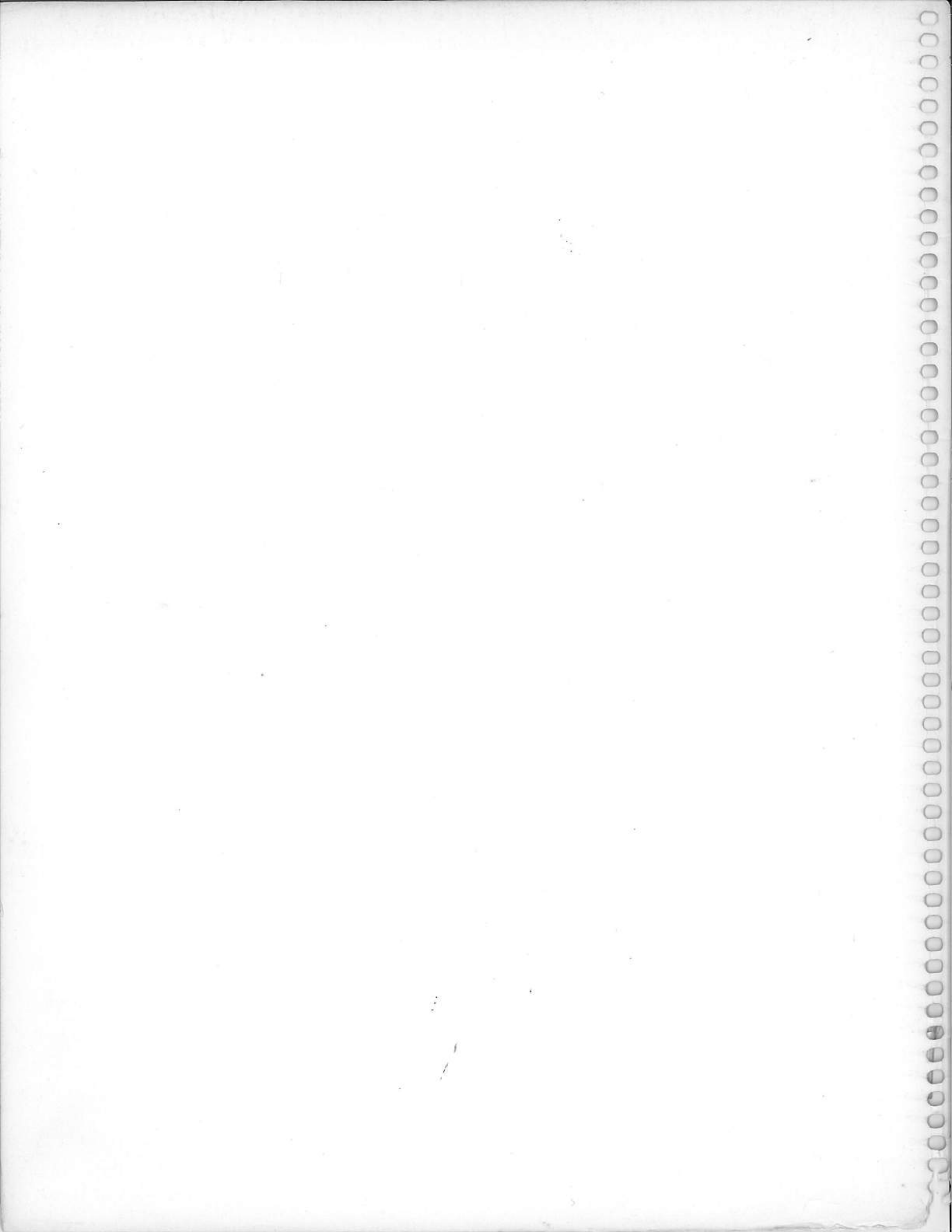

Family Planning Service Delivery Practices of Private Physicians in Jamaica

Final Report

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Preface

The National Family Planning Board (NFPB) was officially enacted by the National Family Planning Act of 1970 as the principal agency of Government responsible for preparing, carrying out and promoting family and population programmes in Jamaica. In the overall health system, the NFPB plays a central role in binding together the various elements of family planning into a comprehensive programme.

The National Family Planning Programme now stands at a crucial point in its 26 year history. Among the challenges facing it is an incremental phase out of donor financing for most of the contraceptives distributed in the public sector programme. At the same time, Jamaica's economic decline has reduced the Government's revenue available to expand the programme. Because of this, the NFPB has revised its programme strategy to:

- reduce the pressure on the public health services budget, by encouraging greater private sector participation in the family planning programme; and

- shift users from a heavy reliance on supply methods to long-term methods.

Long-term methods are cost effective in two ways. First, as effective methods become a larger share of the national method mix, fertility targets become easier to achieve and fewer users are needed to achieve similar reductions in fertility. Secondly, long-term methods are cheaper to provide in terms of couple years of protection.

Private physicians are providers of health care for a significant proportion of Jamaican women. Although only 12 percent of these women see a private physician for family planning services, 67 percent of the women or their families, at some time, see a private physician. Services must, however, be accessible, both in terms of availability and in terms of ease of access, to encourage use among potential contraceptors.

In this regard, a study funded from the USAID Family Planning Initiatives Project, through a buy-in with the OPTIONS II project, and with assistance from Family Health International, was conducted to identify and map family planning service delivery points as well as:

- identify types of family planning services provided at each point, inclusive of counselling and the times during which the services are provided; and

- determine the attitudes, skills and interest levels regarding long-term methods and provision of family planning services among private sector providers.

The results of this study will be used to help the NFPB move towards programme sustainability through expanding the role of the private sector in family planning.

Beryl Chevannes (Mrs.)
Executive Director, NFPB
March, 1994

Acknowledgements

This report and the private physicians' survey upon which it is based depended on the goodwill and active participation of over 400 general practitioners, obstetricians, gynecologists and urologists in private practice who gave so generously of their time. It is hoped that these and other medical professionals in Jamaica will benefit from the findings of the study.

The authors would like to thank the leadership of the National Family Planning Board, Mrs. Beryl Chevannes, Executive Director, and Mr. Lennox Deanne, Executive Director (Acting), for its general support and oversight which facilitated every aspect of this study. Special appreciation is extended to Professor Hugh Wynter, Director of Advanced Research and Fertility Management of the University of the West Indies, who reviewed the initial draft report and contributed valuable insights to shape clinical family planning issues in the context of reproductive health and epidemiology in Jamaica.

We are also grateful to Dr. Margaret Green, President of the Medical Association of Jamaica, for her endorsement of the study which encouraged physicians to participate in the survey, as well as her seasoned knowledge and guidance which helped conceptualize the report framework.

The field work and data processing for this study involved handling over 800 variables, which required an enormous effort from the entire field and data entry staff, whose dedication made this survey a success. We would like to thank the field supervisors: Mrs. Jean Munroe, Mrs. Jean Jackson, Mrs. Amy Lee, and Miss Patricia Oliver. Also, Dr. Vincent George and his team of university students who handled computer data entry are commended for their diligence and high quality performance.

And, finally, this study would not have been possible without the indispensable financial support from the United States Agency for International Development.

List of Abbreviations

AIDSCAP	AIDS Control and Prevention Program (FHI)
AVSC	Access to Voluntary and Safe Contraception, International
COCs	Combined Oral Contraceptives
CPS	Contraceptive Prevalence Survey
FHI	Family Health International
FPIP	Family Planning Initiatives Project
INTRAH	Program for International Training in Health
IPPF	International Planned Parenthood Federation
IUD	Intra-uterine Device
KMA	Kingston Metropolitan Area
MAJ	Medical Association of Jamaica
MOH	Ministry of Health
NAJ	Nursing Association of Jamaica
NFPB	National Family Planning Board
OB/GYN	Obstetrician/Gynaecologist
OCs	Oral Contraceptives
PAHO	Pan American Health Organization
PID	Pelvic Inflammatory Disease
STDs	Sexually Transmitted Diseases
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
UWI	The University of the West Indies
VSC	Voluntary Surgical Contraception
WHO	World Health Organization

Executive Summary

Background

The expansion and sustainability of family planning services is one of the National Family Planning Board's highest priorities, in large part through encouraging the participation of the private sector. The purpose of the study was to collect baseline information on family planning service delivery islandwide which the NFPB will use to develop a pilot project to expand private physician's role in providing family planning services. The specific objectives of this component of the study were to determine the consistency of care given to family planning clients, and to determine if private providers are basing service delivery practices on up-to-date scientific information on contraceptives.

This study was conducted as part of a mapping study of all service delivery points in Jamaica. This report is a companion to the report on that aspect of the study, titled "Mapping Study and Private Physicians' Survey: Opportunities for Expanded Family Planning Services in Jamaica," by Bailey et al., 1994.

Methodology

Interviews were conducted with 407 private practitioners who were potentially involved in the delivery of family planning services (a 97 percent response rate). Field work took place between July 5 and September 17, 1993. This report is based on the findings from 367 private physicians who said they offer either family planning services or counselling. Private physicians were asked about their background, their service delivery practices, and factors that affect their provision of methods, including preference for and opposition to any methods of family planning. Variations in the practices of the physicians and Jamaican and international guidelines were highlighted as part of the study.

Profile of Private Service Providers

Three hundred and sixty-seven private physicians provide family planning services in Jamaica, mostly through one practice location (76 percent). Most of the private physicians are male general practitioners, and half have been in practice between six and 15 years. About half of the doctors say they see between one and ten family planning clients a day.

Most (88 percent) of the physicians have received family planning training either during or after medical school. The contraceptive methods provided or prescribed by the private physicians include the oral contraceptive pill (hereafter referred to as the pill) (97 percent), the condom (68 percent) and the injectable Depo-Provera (66 percent), followed by the IUD (48 percent) and barrier methods (41 percent). Half of the doctors say they provide natural family planning. Thirteen percent offer female sterilization. In most cases the physicians provide family planning services themselves (rather than relying on a nurse or other staff member), and spend, on average, up to 20 minutes counselling their clients.

Service Delivery Practices

Eligibility criteria. A pattern emerges in the age criteria physicians use for contraceptive methods. The pill is generally first given to younger clients (beginning with those under 15 years of age), while Depo-Provera and the IUD are provided to clients aged 16-24, and sterilization is considered a method for women aged 25-30 or more. Depo-Provera and IUD users are generally required to have one or two children and users of female and male sterilization to have two or three children. In screening for medical and social criteria for hormonal methods, physicians are generally interested in smoking and age, cardiovascular problems, varicose veins, irregular bleeding and blood pressure. For the IUD, physicians look for PID/STDs, irregular bleeding, pelvic/cervical cancer, and multiple partners. For female sterilization, physicians generally screen for marital status and understanding of the irreversibility of the procedure. No other medical or social criteria was listed by more than 20 percent of the physicians for the provision of sterilization.

When asked what percent of clients do not meet all the eligibility criteria for a method, physicians said that clients seeking male sterilization are least likely to be turned away, while those screened for the IUD are most likely not to meet all of the eligibility criteria. The average percentage of clients that do not meet the screening criteria, as estimated by the physicians, is 18 percent for the IUD, 15 percent for Depo-Provera, 12 percent for the pill, 11 percent for female sterilization, and nine percent for male sterilization.

Parental Consent. Nearly half of the physicians require parental consent for contraceptive use by teenagers. For teenage clients without parental consent, 24 percent of the physicians said they would suggest another method, while 19 percent said they would provide the method to the teenager even without parental consent. Another 16 percent said they would not provide a method to the teenager, while 13 percent would try to convince the parents to allow their child to use contraception.

Medical and laboratory tests required. There is a wide range by method in the percent of providers who require tests prior to contraceptive use. For males seeking sterilization, for example, 68 percent of the physicians require tests, compared to 98 percent of the physicians who require tests for clients being screened for IUD use. Over half of the physicians say they take a clinical history and over 60 percent say they perform a complete physical exam before

providing any of the contraceptive methods. Other common tests are weight, pelvic exam, pap smear and blood pressure. Over 20 percent of the physicians require urine analysis before prescribing a contraceptive method, except for female barrier methods. A smaller percent of the physicians require laboratory analysis of blood and STDs. Only a small percent of physicians require pregnancy tests prior to contraceptive use. Forty percent of clients are able to get the tests on site or within the greater facility.

Follow-up visits. The average number of recommended follow-up visits for pill users is 2.7 in the first year and 1.4 in the second year, with a range between one and more than five visits. Similar to the OC, the average number of IUD visits is 2.4 in the first year and 1.4 in the second year, with a range between one and five visits.

Medical and laboratory tests required. For all methods, fewer physicians require tests during follow-up visits than before initial use of the method. The percent of physicians requiring no tests at follow-up ranges from 10 percent for IUD users to 31 percent for users of female barrier methods. Still, a large percentage of the physicians say they require a physical exam, check a client's weight, conduct a pelvic exam and take their blood pressure.

Rest period from contraceptive use. More than one-half of the physicians (53 percent) say they recommended a rest from the OC, followed by 40 percent of the physicians indicating a rest from Depo-Provera and 29 percent recommending a rest from the IUD. The reasons listed for the pill and Depo-Provera are similar; physicians worry about reactivating normal hormone flow and eliminating chemicals from the body after three years, and about reducing complications and bleeding. Reasons given to rest from the IUD are if the client has an infection (32 percent) and as a way to reduce the chances of PID or infection (22 percent).

Reasons to postpone provision. Three-quarters of the physicians say there is no reason to postpone the provision of male sterilization, followed by 56 percent who can think of no reason to postpone the provision of female sterilization. IUD users were the most likely clients to face a wait before the provision of that method; only 10 percent of the physicians say they have no reason to postpone provision of the IUD.

Nearly half of the physicians consider menstruation a factor in timing of provision of the female contraceptive methods, including sterilization. Breastfeeding of less than six weeks is a factor for use of some methods, mentioned by between 22 percent (for the IUD) to 81 percent (for the pill). For the female methods, waiting for the results of a pregnancy test is a reason to postpone the provision of the method for between one-quarter and one-third of the physicians. Counselling is considered important for the timing of female and male sterilization, to ensure that the client has time to think about the method. The provision of an IUD would be postponed by only 49 percent of the physicians due to the presence of PID/STDs or an infection. For both the IUD and Depo-Provera, 34 percent of the physicians consider lack of supplies and equipment a reason to postpone the provision of those methods, compared to between 29 and 30 percent for male and female sterilization and 11 percent for the OC.

When physicians postpone the provision of a method, their first choice is to provide another method (mentioned by 82 percent), followed by telling the client to return later (30 percent), and referring the client to another provider (14 percent). Thus, it is possible that nearly two in ten clients may not be getting another contraceptive method to use during the postponement period.

Preferences for methods. Providers show a strong preference for the pill, both for delaying and spacing childbearing (90 percent for delaying and 75 percent for spacing). An additional 13 percent of the physicians prefer the IUD for spacing. For limiting childbearing, the choice is female sterilization, mentioned by 80 percent of the physicians. Reasons listed for preferring certain methods included efficacy, safety, lack of side effects, and acceptability.

Opposition to methods. Nearly half (40 percent) of the providers profess to being opposed to at least one method. Of those opposed to a method, about one-third of the physicians each cite opposition to Depo-Provera (31 percent) and natural family planning (33 percent). Although abortion is not a family planning method, but rather is used to regulate fertility in cases of unwanted pregnancy, 34 percent of the physicians spontaneously reported opposing abortion. An additional 12 percent said they are opposed to female barrier methods. Reasons for opposition to methods included failure rates, side effects, safety, long-term effects on fertility, and morality.

Conclusions and Recommendations

Conclusions

- Private physicians' practices are influenced by the socio-cultural and health environment within which they operate. Private providers, who provide 38 percent of family planning services in Jamaica (CPS, 1994), sincerely desire to provide high quality care and to ensure the safe use of contraceptives. The high incidence of hypertension and diabetes in Jamaica may be factors considered in restricting hormonal methods to some clients, using guidelines more cautiously than international recommendations. Practices are also affected by the likelihood that clients have multiple partners. Physicians' opinions of contraceptives are probably affected by the social view of menstruation and the value of fertility.

- There is a need to standardize the consistency of care given to clients. A client seeking services from different providers may be given a method by one provider and not by another. While it is clear that each individual client must be screened according to his or her own circumstances and conditions, more consistency of care may be warranted islandwide. The method a client uses is likely to be influenced by the provider's preferences among the methods. A client using a hormonal method or the IUD is likely to be encouraged to take a periodic rest from her method. Some clients whose provision of a method is postponed may be sent away with no other method and told to return to the service provider later. Men seeking sterilization have fewer requirements than women, including age, parity, marital status, other screening criteria, exams and laboratory

analyses. Many private physicians will not provide teenage clients with contraception without the consent of parents.

- The health risks of clients using various methods of contraception should be carefully considered against the risk of unplanned pregnancy which may occur when using less effective methods or no method at all. Estimates of the proportion of clients not meeting eligibility criteria appear to be high.

- Choice of methods is restricted in some practices. Some reasons for this are:

  a. Provider preference. The method a client uses is likely to be influenced by the provider's preferences among methods.

  b. Procedures are required by providers that are no longer (or are not) necessary for the correct use of contraception (for example, a number of follow-up visits during contraceptive use, rest period requirements for some methods, and laboratory tests)

  c. Technical competence. Some physicians may not be providing optimum quality care to clients by failing to screen for important health conditions associated with various contraceptive methods (e.g. unexplained irregular bleeding, tobacco smoking and age, cardiovascular problems, PID/STDs).

Recommendations

Through research and experience, knowledge of contraceptive methods continually improves, as do the design and formulation of contraceptive methods. Reasons for service practices in Jamaica merit careful examination in light of current worldwide information on contraceptive methods. Many practices will be justified due to local Jamaican conditions for women and men using contraception, while others, once carefully evaluated, may be deemed unnecessary for the safe use of contraception.

- **Consistency of practice guidelines.** Service delivery guidelines can play an important role in standardizing the care that clients receive from service providers in any country. In 1991, the Ministry of Health and the National Family Planning Board developed national service delivery guidelines for family planning in the public sector. One-quarter of the private physicians know of the service delivery guidelines, a finding consistent with the fact that the guidelines were targeted to the public sector, but, due to funding constraints, were not widely disseminated. WHO will be updating medical criteria for selection of contraceptive methods in 1994, based in part on the work of a working group to update service delivery practices regarding hormonal methods and the IUD. When finalized, the recommendations from WHO should be put in the context of local medical and service delivery conditions in Jamaica.

Through a participatory process of review by a wide range of service providers and relevant organizations (such as the NFPB, the MOH, the MAJ and the NAJ) in the country. Jamaica's *Family Planning Service Delivery Manual* could be updated and disseminated to provide protocols on each contraceptive method. By the admission of the private providers, there will be great demand for the manual among both private and public sector physicians who provide family planning in Jamaica.

- In addition, **training curricula** could be reviewed together with the service delivery guidelines to ensure consistency between the training providers receive and the guidelines they are given. Regular and refresher training could be conducted for private physicians to update them on contraceptive technology and the safe provision of family planning services. Revising the guidelines and providing training will help ensure that the care given to clients is more consistent across providers. Training in counselling for informed choice could help alleviate biases in the provision of contraception.

- A **legal and regulatory analysis** is being conducted in 1994, to review laws and regulations regarding contraceptives and family planning. Issues that have arisen in this study regarding parental and spousal consent, for example, are being addressed. The denial of contraceptive services to adolescents must be carefully examined against the health and socio-demographic implications of adolescent fertility.

- **Continuing education** for providers on contraceptive technology is important for improving both the ability and the quality of services. Subject areas for seminars must not only include clinical protocols for contraceptive use, but communication skills, counselling, and motivational techniques. A substantial proportion of the physicians who responded positively to the pilot project hope that participation will allow them access to educational materials and counselling aids for their clients (62 and 54 percent respectively.) They also are interested in projects that will upgrade their skills in contraceptive technology, clinical techniques and family planning counselling (59, 50, and 33 percent respectively).

SECTION I.

BACKGROUND, PURPOSE AND METHODOLOGY

Chapter 1: Background and Purpose

"I hope that something positive will come from this study and that there will be an increase in acceptance of family planning in the population."

Private Physician, Jamaica[1]

A. Background

Since the 1970s, the National Family Planning Board and the Ministry of Health have developed and sustained a successful National Family Planning Programme. Jamaica's family planning programme is relatively mature, with a contraceptive prevalence rate (CPR) of 62 percent, yet 76 percent of women in the 1993 Contraceptive Prevalence Survey (CPS) report that their last birth was either unwanted or mistimed (NFPB, 1993). Fertility remains at three children, on average, per woman, and the current method mix is strongly balanced in favor of supply methods. Services are available in both public and private sectors; the public sector predominates. The public sector is the primary provider of sterilization and injectables, while the private sector is playing an increasingly important role in the provision of condoms and the pill.

The NFPB has been reliant on donor funding over the years, particularly USAID, UNFPA and the World Bank. Currently, however, donors are reducing financial, technical and commodity assistance. USAID, for example, will withdraw all assistance for family planning by 1998. The projected decrease in donor support will require private sector services to assume greater prominence and is prompting family planning services and organizations in Jamaica to strive to improve their managerial and financial capabilities to sustain family planning services in the long run.

Mindful of declining donor support, and in keeping with the Government of Jamaica's target of replacement level fertility by the end of the century, the National Family Planning Board (NFPB) has developed a broad-based five-year strategic plan which articulates the key issues and interventions to be implemented. The expansion and sustainability of family planning services is the highest priority, in large part through mobilizing the private sector, including the for-profit commercial sector, private medical providers and non-profit non-governmental organizations.

To design private sector interventions, the NFPB considered it important to have a clear understanding of the availability of existing services and the service practices of private physicians. Such an understanding would enable programme managers to emphasize methods for which there is poor availability and to target underserved geographic areas. In addition, if private

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[1]This and the following quotes in this report were taken from comments made by the private physicians at the end of their interviews, when they were asked if they had any additional comments. The quotes were chosen to highlight the themes of the report.

practitioners' participation were to be increased it was also considered important to understand their attitudes and skill level regarding contraceptive methods.

This policy research study entitled "Mapping Study and Private Physicians' Survey" was conducted on behalf of and in collaboration with the National Family Planning Board (NFPB), and in cooperation with the Medical Association of Jamaica. Funding and technical assistance for the study was provided by USAID through The Futures Group OPTIONS II Project and Family Health International (FHI). The fieldwork was conducted by the Fertility Management Unit and the Institute for Social and Economic Research of the University of the West Indies (UWI). The results of the mapping study component of this research are presented in a separate report, entitled "Mapping Study and Private Physicians' Survey: Opportunities for Expanded Family Planning Services in Jamaica," by Bailey et al., 1994.

The NFPB, a statutory board enacted by the National Family Planning Act in 1970, is the principal agency responsible for preparing, carrying-out, and promoting a nation-wide family planning programme. The OPTIONS II project is part of the USAID-funded bilateral agreement (Family Planning Initiatives Project) between the Government of Jamaica and the United States Agency for International Development, and has been providing broad-based technical assistance to advance policy development on behalf of the NFPB for two years. Family Health International is a nonprofit research and technical assistance organization dedicated to contraceptive development, family planning, reproductive health and stemming the spread of AIDS. FHI works in Jamaica through the AIDSCAP project and more recently with the NFPB to assist in the improvement of service practices.

B. Purpose

The overall purpose of the study was to collect baseline information on family planning service delivery islandwide, which the NFPB will use to develop a pilot project to expand private physician's role in providing family planning services.

The specific objectives of this component of the study on service delivery practices were to:

- Assess service delivery practices to determine the consistency of care given to family planning clients; and
- Determine if private providers are basing service delivery practices on up-to-date scientific information on contraceptives.

This study was a follow-up to a study conducted among private physicians, conducted by Hope Enterprises in 1991. That study of 75 private physicians reviewed their experience with family planning and interest in expanding their provision of contraceptive services.

Chapter 2: Research Methodology

This study comprised two parts: the mapping of all facilities on the island which offered family planning methods and services and a survey of private physicians providing family planning services. The research design involved a combination of reviewing records, validation through telephone inquiries and interviews with key personnel as well as face-to-face field work. The methodology for the mapping study is reported elsewhere.

A. Fieldwork

Face-to-face interviews with private practitioners formed one phase of the research project. The UWI team worked collaboratively with the NFPB, OPTIONS II and FHI to develop the questionnaire (Appendix A), which was to be administered to all private sector general practitioners and those specialists who were likely to be involved in the delivery of family planning services. Members of the research team are listed in Appendix B. Four groups of private physicians were targeted--General Practitioners, Obstetricians and Gynecologists (OB/GYN), Surgeons and Urologists. To ensure the widest possible participation in the project, the research team sent letters by post to all medical physicians who met the criteria to inform them of the purpose of the project and the timing of the field phase, and request their cooperation with the interviewers (Appendix C). The same information was contained in news releases appearing in the press. Interviewers personally delivered a second letter written jointly by the Medical Association of Jamaica, the NFPB, and the UWI research team (Appendix D).

The interviewer training programme in preparation for the field phase was conducted at the UWI from June 24 to June 26, 1993. Sixteen persons comprising mainly graduate students of the UWI and nurses were introduced to the objectives of the study and trained in interviewing techniques by representatives of the UWI, the Futures Group and FHI. The training included live practice interviews, role playing and pretesting of the physicians' questionnaire.

Field interviews formally commenced during the week beginning July 5, 1993. The majority of the interviews were completed by August 13, 1993; however, the exercise was extended to September 17 to accommodate those physicians who had been on vacation. Periodic checks by Field Supervisors were conducted to ensure accuracy and consistency in data collection. At the completion of the validation process, there were an estimated 418 general practitioners and specialists who were likely to be involved in the delivery of family planning services. The level of cooperation was such that 407 (97 percent) agreed to be interviewed. While traveling around the island to conduct the physician interviews, field workers further validated, through spot checks, listings from other categories of physicians to resolve uncertainties.

Before beginning data entry, five students from the Computing Department of the UWI were given an overview of contraceptive technology by Dr. O. McDonald, Medical Director of the NFPB. Under the direction of Michele Villinski of FHI, the UWI trained and supervised the

students in data entry during the month of August. The software packages used for data entry and analysis were SPSS DEII and SPSS 6.0 for Windows, provided by FHI. Members of the UWI research team and representatives from FHI undertook coding and verification of the questionnaire throughout the months of August and September.

B. Presentation of results

This report is the result of collaboration between the UWI, FHI and The Futures Group, OPTIONS II Project. FHI took primary responsibility for drafting the report and representatives from the UWI, NFPB and MAJ added valuable information to set the findings in the Jamaican context. Representatives from The Futures Group participated in drafting and reviewing the report.

C. Scope of the private physicians survey

Private physicians were asked about their background; specifically they were queried about their specialty, the training they had received in family planning, their years of service, the types of contraceptive services they offer and which staff members in their practice offer the various methods of family planning. In addition, they were asked about client load and time spent on counselling. The physicians were then asked in detail about their service delivery practices, both for initial and continued provision of contraceptives to clients. Specifically, the physicians were questioned regarding the screening criteria they use, the testing they require, any consent teenage clients must have, and rest periods they recommend for contraceptive methods. Finally, the physicians were asked about factors that affect their provision of methods, including reasons they might postpone the provision of methods, and their preference for and opposition to any methods of family planning. Part of the purpose of these questions was to identify "medical barriers", or practices that might be no longer considered medically necessary or appropriate for the safe provision of contraception. At the same time, the survey sought to identify practices that were perhaps not being fully emphasized but that are considered important for contraceptive provision.

The series of questions has been analyzed only for the 367 private physicians who said they either counsel for or offer family planning. Due to time considerations of the interview, the questions in this survey focus primarily on the technical and medical provision of care rather than the inter-personal provision of care. These data represent the views of the physicians on their own service delivery practices. The findings have not been corroborated with findings from client surveys (to assess clients' perceptions of the practices to which they were subjected) or from clinic observations (to measure how often the physicians use the screening criteria and perform the medical and laboratory tests they mentioned, for example). Nevertheless, the data provide an insight into the types and variations in service delivery practices among private physicians in Jamaica, which can be used to facilitate policy dialogue within the medical community.

In this report, following the presentation of the service practices of the providers, the practices are compared, where possible, with the Jamaican *Family Planning Service Delivery Manual*, developed by the Ministry of Health and the National Family Planning Board (MOH and NFPB, 1991), and with the *Guidelines for Clinical Procedures in Family Planning* of the Program for International Training in Health (INTRAH) and other international service delivery guidelines such as the International Planned Parenthood Federation's *Medical and Service Delivery Guidelines* (Huezo and Briggs, 1992), the Medical Barriers Working Group's "Guidance for Updating Selected Practices for Hormonal Methods and IUDS" (1994), Contraceptive Technology International (Hatcher et al., 1989) and the World Health Organization[2]. In addition, scientific evidence is presented to support the suggested international guidelines. INTRAH guidelines are most extensively used because they are widely considered by international family planning experts to be the most current and comprehensive service delivery guidelines available.

It is important to remember, however, that the international guidelines are meant only as a guide on the latest scientific evidence related to contraceptive technology; the guidelines should be adapted for the unique conditions in each country's family planning programme. For example, "Local guidelines should reflect the cultural and practical realities of particular regions and types of service settings; therefore, INTRAH encourages translation and adaptation of *Guidelines* sections that are most appropriate to local settings" (INTRAH, 1993, p. 1). It is also important to note that private physicians were not an intended audience for the Jamaican guidelines; thus most were not aware of the guidelines manual. Similarly, the private physicians were not expected to be aware of the international guidelines. The purpose of this comparison is to present Jamaican service delivery practices in relationship to current international evidence on the safe provision and use of contraception.

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[2]WHO will hold a meeting on March 7-10, 1994 to update medical criteria for selected methods of contraception. The results of the meeting should be available later in 1994.

SECTION II.

PROVIDER PROFILE AND PRACTICES

Chapter 3: Profile of Service Providers

Three hundred and sixty-seven private physicians provide family planning services in Jamaica, mostly through one practice location (table 3.1). The majority (76 percent) are male. Half of the providers have been in practice between 6 and 15 years; the range of service is from one to over 21 years, with an average duration of service of 16 years. Half of the physicians are General Practitioners. An additional 18 percent are OB/GYNs, and 14 percent practice family medicine (figure 3.1).

Most (88 percent) of the physicians have received training in the provision of a variety of family planning services and techniques either during or after medical school (table 3.2 and figure 3.2). Fully 88 percent of all doctors had training in the provision of the pill and 83 percent in Depo-Provera. Methods for which the fewest physicians are trained include male sterilization and, not surprising in view of the small number who were involved in pre-introductory trials funded by the Population Council, NORPLANT insertion. Of those trained, 88 percent feel that their training was sufficient.

The contraceptive methods provided or prescribed by the private physicians include OCs (hereafter referred to as the pill) (97 percent), the condom (68 percent) and Depo-Provera (66 percent), followed by the IUD (48 percent) and barrier methods (41 percent), as shown in table 3.3 and figure 3.2. Half of the doctors say they provide natural family planning. Thirteen percent offer female sterilization.

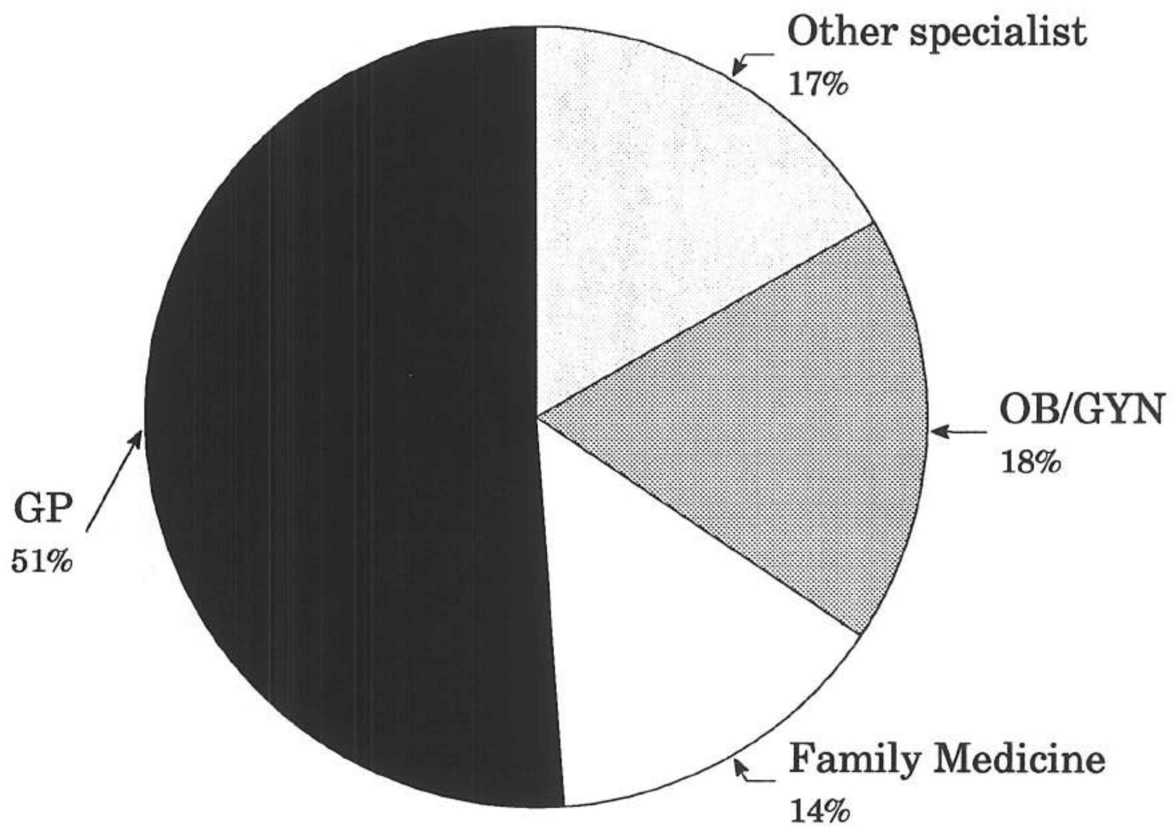
In most cases the physicians provide family planning services themselves (table 3.4). Typically, nurses assist in the provision of counselling and the injectable and rarely in the delivery of other family planning services. Physicians spend, on average, up to 20 minutes counselling their clients (table 3.5).

About half of the doctors say they see between 1 and 10 family planning clients a day, with a range of 0 to 16 or more clients (table 3.6 and figure 3.3). Some of the doctors (14 percent) were not able to estimate their client load for family planning services.

Table 3.1
Characteristics of Private Providers of Family Planning

Characteristic	Percent
Number of practice locations	
1	76.4
More than 1	23.6
Gender	
Male	76.3
Female	23.7
Years Practicing Medicine	
1-5	7.6
6-10	25.6
11-15	22.1
16-20	16.1
21+	28.6
Area of Specialty	
General Practitioner	51.2
OB/GYN	17.7
Family Medicine	14.4
Surgery	6.0
Urology	1.1
Other	9.5
Training	
Yes	88.3
No	11.7
Number	(367)

Figure 3.1: Areas of Specialty Among Private Physicians in Jamaica



Source: Survey of FP Practices of Private Physicians in Jamaica, 1993

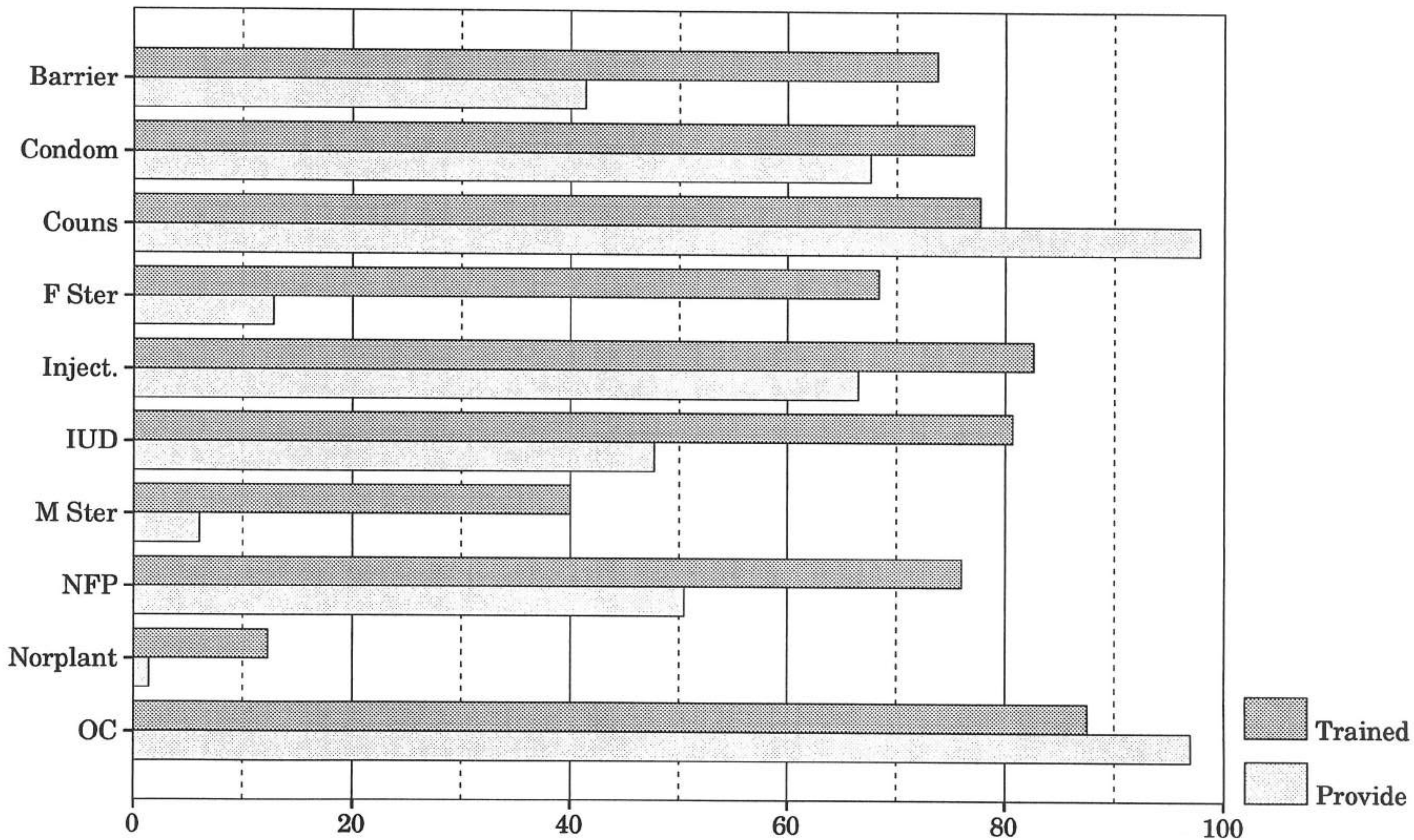
Table 3.2
Training in Contraceptive Counselling and Methods, By Private Providers

Method	Percent Trained
Counselling	77.1
Any method	88.3
Oral contraceptives	87.5
Depo-Provera	82.6
IUD	80.7
Female sterilization	68.4
Male sterilization	39.0
NORPLANT	12.3
Female barrier methods	73.8
Condoms	77.1
Natural family planning	76.0
Other	4.9
Number	(367)

Table 3.3
Provision and Prescription of Contraceptive Counselling and Methods, By Private Providers

Method	Percent Providing
Counselling	97.8
Oral contraceptives	97.0
Depo-Provera	66.5
IUD	47.7
Female sterilization	12.8
Male sterilization	6.0
NORPLANT	1.4
Female barrier methods	41.4
Condom	67.6
Natural family planning	50.5
Other	5.4
Number	(367)

Figure 3.2: Percentage of Private Physicians in Jamaica Trained and Providing Specific Methods



Source: Survey of FP Practices of Private Physicians in Jamaica, 1993

Table 3.4
Provision and Prescription of Methods by Private Provider Staff
(In percent)

Staff member	Counselling/Method					
	Counselling	Pill	Depo-Provera	IUD	Female sterilization	Male steril-ization
Doctor	99.7	100	88.9	100	100	100
Nurse	10.6	3.7	20.6	1.0	2.0	0
Other	1.3	0	0	0	0	0
Number	(367)	(353)	(244)	(174)	(149)	(23)

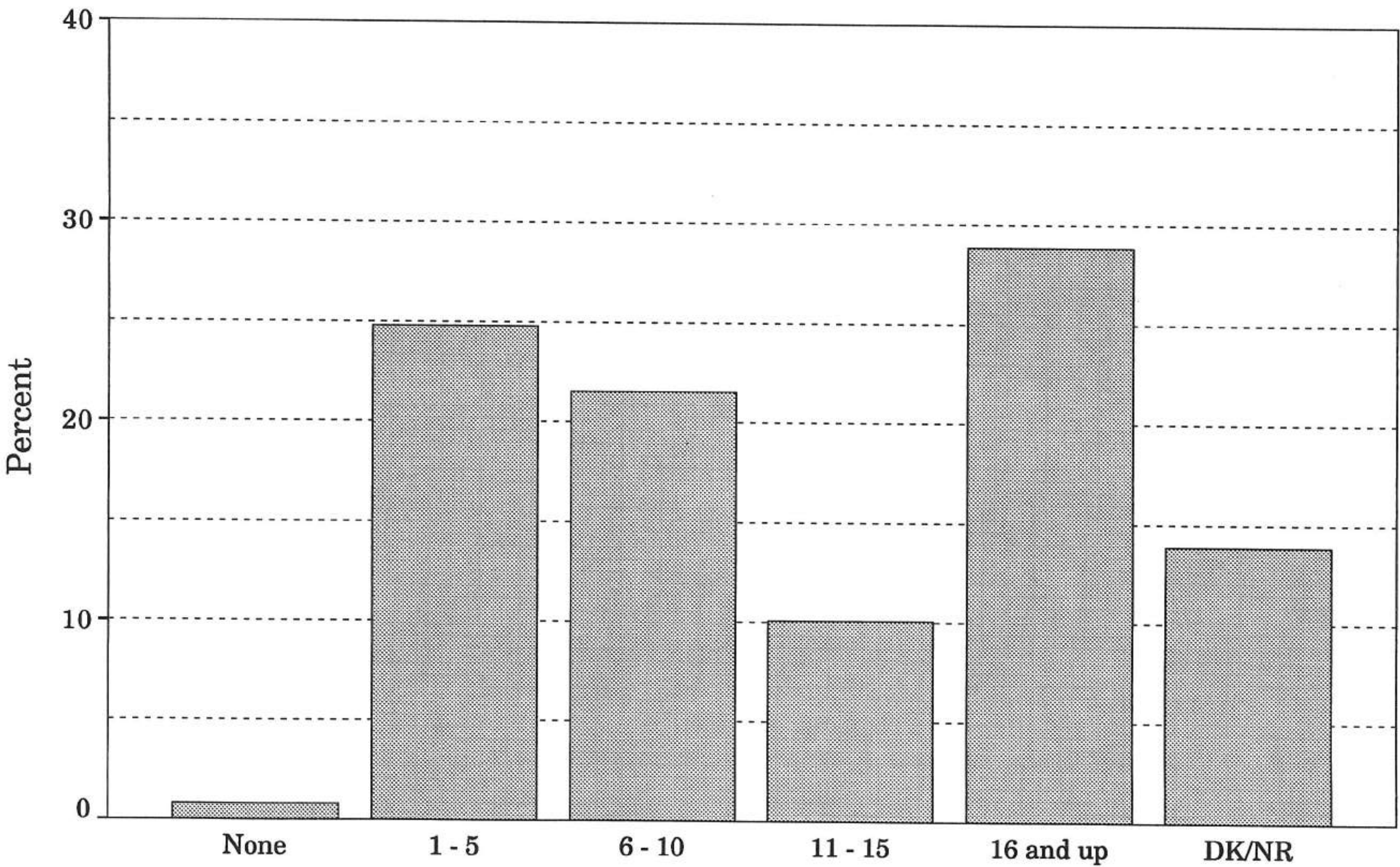
Table 3.5
Time Spent Counselling Family Planning Clients,
By Private Providers in Jamaica

Time spent counselling (minutes)	Percent
0-5	5.2
6-10	29.2
11-15	28.4
16-20	19.7
21-25	1.1
6-30	12.0
More than 30	3.3
Do not know/other	1.1
Number	(366)

Table 3.6
Number of Family Planning Clients of Private Providers

Family planning clients per week	Percent
0	0.8
1-5	24.8
6-10	21.5
11-15	10.1
16 or more	28.9
do not know/no response	13.9
Number	(367)

Figure 3.3: Weekly Family Planning Client Load Among Private Physicians in Jamaica



Source: Survey of FP Practices of Private Physicians in Jamaica, 1993.

Chapter 4: Service Delivery Practices

"It would be a good idea to update doctors on new methods as they become available."

"We need more patient education on the safety of family planning methods, the advantages and disadvantages."

Private Physicians, Jamaica

This chapter reports on the service delivery practices of the 367 private physicians who offer family planning counselling or services.

A. Initial provision of services

1. Eligibility criteria for contraceptive use

Private doctors were asked about eligibility criteria for use of the pill, Depo-Provera, IUD, female and male sterilization. They were asked, *"When considering a client for [the method], what are your eligibility criteria for use?"* Doctors were asked about age and parity requirements, and a number of medical and physical conditions. Some response categories were prompted, although not immediately after the question was asked, while others were spontaneously mentioned by the physicians[3].

a. Age criteria

The physicians' responses regarding minimum and maximum age criteria for use of the pill, Depo-Provera, IUD, and female and male sterilization are shown in table 4.1 and figure 4.1. It is evident that the physicians have different opinions about the appropriate age range for these methods, although age patterns do emerge for each method.

The pill is provided as a method for younger women; 69 percent of the physicians said they give pills to women under age 19. For IUDs, the largest percent of physicians recommend a minimum age between 16 and 24 (45 percent). Depo-Provera has the widest range of minimum age to begin using the method; 70 percent of the physicians gave the age groups of 16-19 to 30 or over as the ages when clients can start Depo-Provera. Physicians gave an earlier age for

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[3]The information on eligibility criteria were difficult to collect from physicians, due to the trade-off in the study between level of detail of the information elicited and length of the interview. In the pretest, physicians were prompted for all criteria listed in the questionnaire; that process proved too time consuming. In the survey, therefore, certain key eligibility criteria for each method were prompted, while others were noted only if mentioned spontaneously by the physicians.

female than male sterilization (an average age of 27 compared to 31). Excluding barrier methods, on average female clients in Jamaica can begin using the pill at age 16 and can end their child-bearing years at age 42 with a sterilization. The age range for male sterilization, on average, is age 31 to age 50.

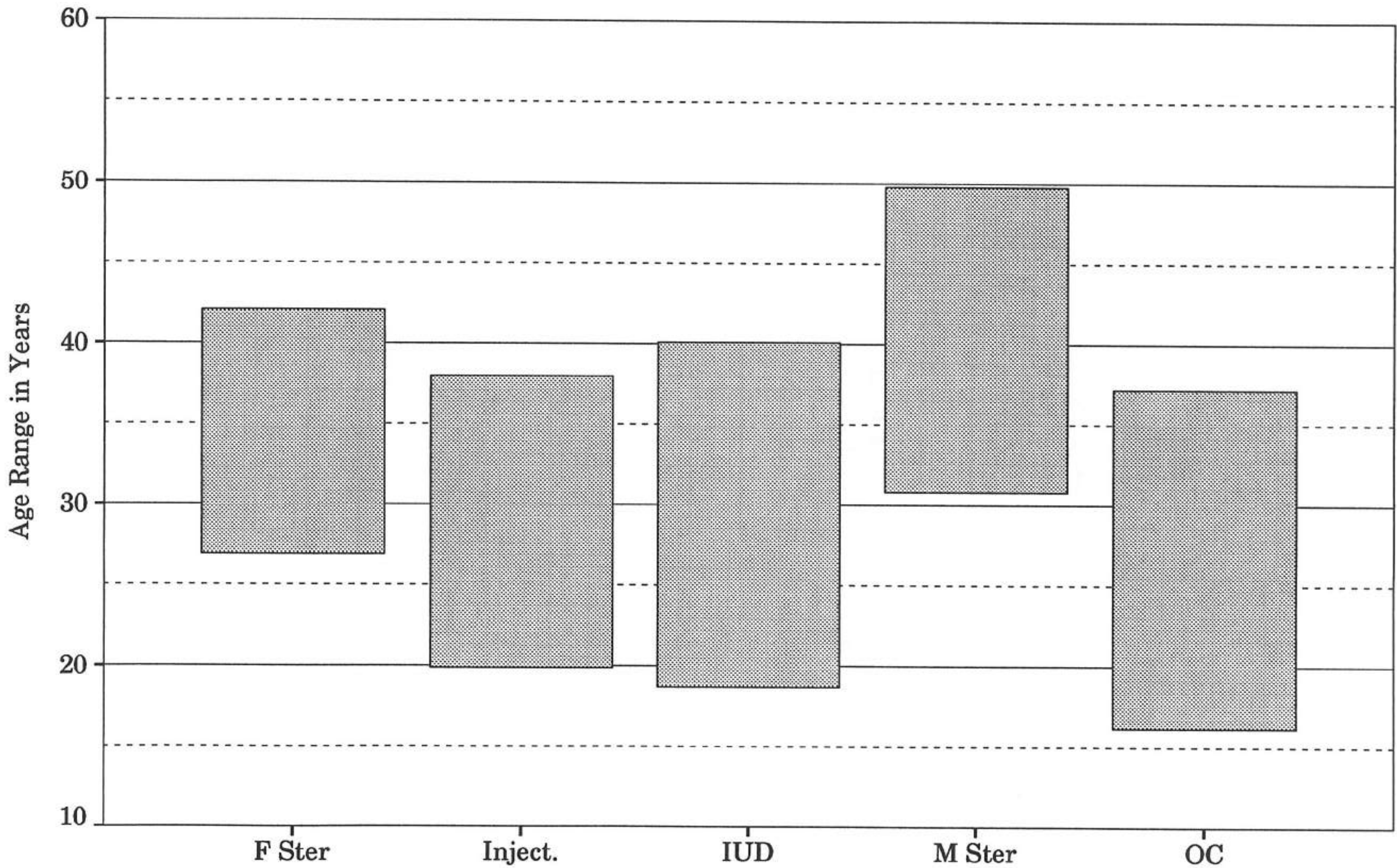
Nearly 70 percent of the physicians said that they had no maximum age requirements for male sterilization, compared to eight percent for the pill and 15 percent for Depo-Provera. Nearly 80 percent of the physicians said that a women should stop taking the pill by age 40 or below. Depo-Provera, also a hormonal method, showed similar results (71 percent). Nearly 40 percent of the physicians thought that women should stop using the IUD at or below age 40.

Table 4.1
Age Criteria for Use of Selected Contraceptive Methods
(In percent)

Restriction	Method				
	Pill*	Depo-Provera	IUD	Female sterilization	Male sterilization
Minimum Age (years)					
None	23.3	18.5	37.1	25.9	33.8
15 or less	23.9	6.9	7.8	1.4	--
16-19	45.5	29.1	25.8	3.7	--
20-24	2.5	24.2	18.8	11.5	5.5
25-29	0.3	14.1	4.7	21.0	9.5
30 or more	0.3	2.2	0.4	28.8	43.4
Menarche	1.1	--	0.8	--	NA
Depends	3.1	5.1	4.7	7.9	8.1
Average minimum age	16.2	19.9	18.7	26.9	30.8
Maximum age (years)					
None	8.1	14.9	37.5	43.5	68.5
35 or less	47.9	37.0	11.0	4.6	1.4
36-40	31.2	33.7	26.6	19.0	2.7
41-45	7.9	9.8	13.3	19.9	4.1
46 or more	0.6	1.5	3.9	3.4	12.3
Menopause	2.2	0.7	4.7	4.6	NA
Depends	2.2	2.5	3.1	5.1	11.0
Average maximum age	37.2	38.0	40.1	42.1	49.8
Number	(356)	(276)	(256)	(216)	(73)

Note: percentages may not add to 100 due to rounding.
* In this and future tables, results for the pill refer to the combined oral contraceptive.

Figure 4.1: Mean Minimum and Maximum Age Criteria for Access to Family Planning Methods



Source: Survey of FP Practices of Private Physicians in Jamaica, 1993

Note: Excludes those who did not list age criteria for specific methods.

b. Parity criteria

Parity requirements are shown in table 4.2 for four methods: Depo-Provera, the IUD, and female and male sterilization. Between nine and 20 percent of the physicians do not require clients to have any children prior to using these methods. The majority (91 percent) of the physicians specify that a client must have at least one child before using Depo-Provera, and 80 percent say that a client must have at least one child before using an IUD.

Physicians are more concerned that women have children before receiving a sterilization (94 percent) than that men have children before having a vasectomy (80 percent). In the case of sterilization for both men and women, nearly half of the physicians require that the client have at least two children; an additional 16 percent of physicians require men to have at least three children. Nearly a quarter (24 percent) of the private physicians require female clients to have three or more children. Although not specifically asked about parity requirements for the pill, 5.2 percent of the physicians mentioned that parity was one of their eligibility criteria for that method.

Table 4.2
Parity Requirements for Contraceptive Use, for Selected Methods
(In percent)

Minimum number of children	Method			
	Depo-Provera	IUD	Female sterilization	Male sterilization
None	9.1	19.5	6.5	20.3
One	47.1	58.6	9.3	8.1
Two	27.7	13.3	47.7	44.6
Three	9.9	4.7	23.6	16.2
Four	3.3	2.0	6.9	4.1
Five or more	0.7	0.4	2.3	-
It depends	2.2	1.6	3.7	6.8
Number	(274)	(256)	(216)	(74)

Note: percentages may not add to 100 due to rounding.

c. Other medical and social criteria

Private physicians were asked about medical and other conditions they screen for when prescribing contraceptives. Table 4.3 presents the other conditions mentioned by the physicians. Again, those few conditions prompted for are noted with an asterisk (*). Generally, the IUD and male sterilization had the fewest eligibility criteria.

Table 4.3
Eligibility Criteria For Selected Contraceptive Methods Listed by Private Physicians
(In percent)

Restriction	Method				
	Pill	Depo-Provera	IUD	Female sterilization	Male sterilization
Medical					
Tobacco smoker	62.1*	50.0*	--	--	--
Tobacco smoker over certain age	58.7*	50.4*	--	--	--
Diabetes	37.1	29.0	--	14.8	8.1
Liver condition	37.1	31.5	--	10.2	5.4
Varicose veins	55.1	37.3	--	9.7	2.7
Breast lump/cancer	35.7	29.3	--	8.8	NA
Pelvic/cervical cancer	--	--	32.8	--	NA
Sickle cell disease	15.2	12.7	1.2	12.5	6.8
Irregular bleeding	24.2	43.1	40.8	9.3	NA
Aneamia	11.0	11.2	12.2	8.8	4.1
Cardiovascular problems*	60.7	37.3	14.5	16.2	1.4
Respiratory problems	11.5	9.4	9.8	10.2	1.4
PID/STDs	12.6	9.1	81.6	10.2	6.8
Breastfeeding	13.2	10.1	9.0	3.2	NA
Weight	13.5	9.1	0.8	4.2	2.7
Migraine	13.2	2.5	--	--	NA
Fibroids	2.5	1.4	6.7	--	NA
Contraindicated for other method/risk of pregnancy	--	--	3.9	8.3	--
Genetic diseases	--	--	--	--	4.1
Spouse's health	--	--	--	--	4.1

Restriction	Method				
	Pill	Depo-Provera	IUD	Female sterilization	Male sterilization
Social					
Married	--	--	--	38.9*	39.2*
Stable relationship	--	--	--	--	5.4
Multiple partners	--	--	57.4	--	--
Compliance	4.0	2.9	--	--	--
Counselling on irreversibility	NA	NA	NA	12.5	21.6
Husband wife agree no more children	NA	NA	NA	6.5	--
Mental/emotional problems/post-partum depression	--	1.1	--	10.6	5.4
Other	35.3	20.5	25.5	19.9	16.2
Number	(356)	(276)	(256)	(215)	(74)

Note: Percentages do not add to 100 because multiple responses were possible.

* Indicates that respondents were prompted for this criteria.

** Cardiovascular problems also include hypertension, thrombosis and deep vein thrombosis, leg pain, clotting disorders, heart disease and rheumatic fever.

Over one-third of the physicians require clients undergoing either female or male sterilization to be married (39 percent for both methods), while tobacco smoking is a screening criterion for use of hormonal methods (the pill and Depo-Provera, 62 and 50 percent, respectively). Although they do not specify the age, over half of the physicians say that age is a factor when determining eligibility for women who smoke who are being screened for use of hormonal methods.

Diabetes, liver condition, varicose veins, breast lump/cancer and sickle cell disease are common screening criteria, particularly for the hormonal methods (the pill and Depo-Provera.) Irregular bleeding is a concern particularly for Depo-Provera and the IUD. All methods are subject to screening for anaemia, cardiovascular and respiratory problems, and PID and STDs.

For the pill, the criteria mentioned by over 50 percent of the private physicians, are smoking, varicose veins, and cardiovascular problems. For Depo-Provera, the only screening criterion listed by over 50 percent is smoking. For the IUD, two factors are listed by more that half of the physicians: PID/STDs and multiple partners. No criterion is listed by more than half of the physicians for either female or male sterilization.

d. Blood pressure criteria

The private physicians were asked about the blood pressure criteria they use when screening clients for use of the pill and Depo-Provera. Table 4.4 lists the results. The criteria for use varies from no set blood pressure criteria, to a range of more than 20 points for both systolic (130 or lower to 151 or higher) and diastolic (80 or lower to 101 or higher). Most physicians listed a systolic level between 131 and 150 (57 percent for the pill and 53 percent for Depo-Provera) and a diastolic between 81 to 90 (62 percent for the pill and 58 percent for Depo-Provera). The average minimum and maximum blood pressure points noted by the private physicians is virtually the same for both the pill and Depo-Provera: An average systolic of 138 and diastolic of 89.

Table 4.4
Blood Pressure Criteria for the Pill and Depo-Provera
(In percent)

Blood pressure	Method	
	Pill	Depo-Provera
Systolic		
None	7.1	16.2
130 or lower	29.7	25.0
131-150	56.7	52.8
151 or higher	6.7	5.9
Average	138.1	138.1
Diastolic		
None	5.1	14.3
80 or lower	20.1	15.4
81-90	61.7	57.9
91-100	12.3	11.4
101 or higher	0.9	1.2
Average	88.7	89.3
Number	(350)	(273)

Note: Percentages may not add to 100 due to rounding.

Those who noted hypertension, without specifying numeric criteria, are included under "cardiovascular problems" in table 6.5.

e. Summary of eligibility criteria

This review of eligibility criteria suggests that providers use various age criteria for different contraceptive methods, although a pattern emerges. The pill is generally first given to younger clients, while Depo-Provera and the IUD are provided to clients aged 16-24, and sterilization is

considered a method for women aged 25-30 or more. Physicians generally require Depo-Provera and IUD users to have one or two children and users of female and male sterilization to have two or three children. In screening for medical and social criteria for hormonal methods, physicians are generally interested in smoking and age, cardiovascular problems, varicose veins, irregular bleeding and blood pressure. For the IUD, physicians look for PID/STDs, irregular bleeding, pelvic/cervical cancer, and multiple partners. For female sterilization, physicians generally screen for marital status and understanding of the irreversibility of the procedure. No other medical or social criteria was listed by more than 20 percent of the physicians for the provision of sterilization.

2. *How many clients do not meet the screening criteria for contraceptive use?*

In addition to the screening criteria for clients seeking contraception, the private physicians were asked, *"Of the clients you screen for [method], what, in your estimate, is the percent who do not meet your eligibility criteria?*[4]" The results, presented in table 4.5 and figure 4.2, are clearly estimates, and, according to anecdotal evidence from interviewers, many of the physicians gave their answers a lot of thought, indicating that they had not thought before about how many clients are excluded from using various methods of contraception. The purpose of this question was to gain a sense from the physicians about the impact of their screening criteria on clients' access to contraceptive use.

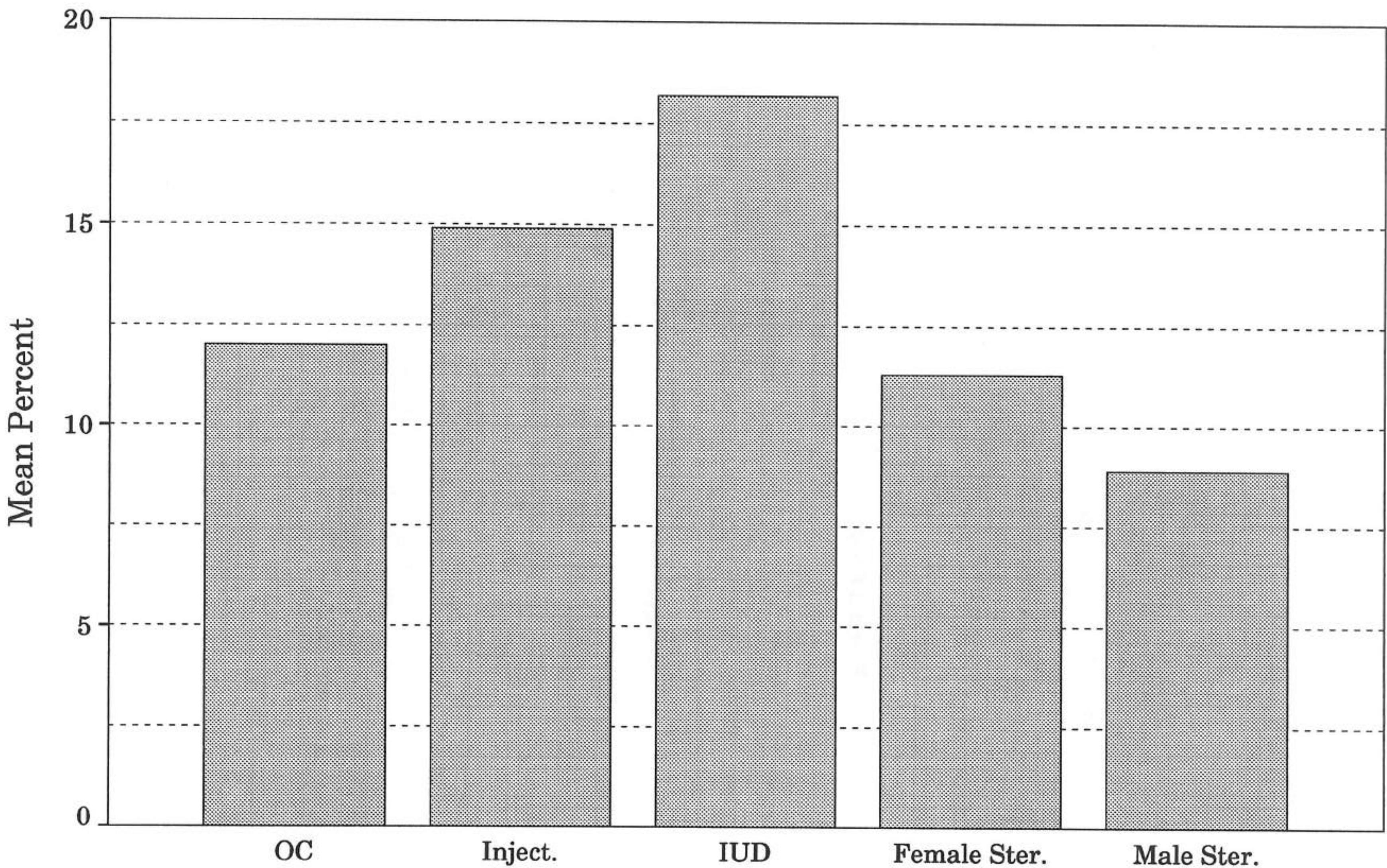
Table 4.5
Physician's Estimate of Clients Who Do Not Meet Eligibility Criteria, for Selected Contraceptive Methods
(In percent)

Method	Estimated percent not meeting eligibility criteria								Number
	O	1-4	5-9	10-19	20-29	30+	Do not know	Average	
Pill	2.8	23.9	23.9	24.4	9.3	8.8	7.0	12.0	(356)
Depo-Provera	3.6	20.7	17.9	20.8	13.1	13.9	10.2	14.9	(275)
IUD	5.1	18.8	11.4	20.7	9.8	23.6	10.6	18.2	(256)
Female sterilization	15.3	22.4	19.6	16.7	5.2	9.1	11.7	11.3	(215)
Male sterilization	34.2	28.8	9.6	2.7	1.4	8.3	15.1	8.9	(73)

Note: Percentages may not add to 100 due to rounding.
The average figures are based on the each physician's estimate of the percent of clients who do not meet the screening criteria for the various methods.

[4]In retrospect, it might have been more clear to ask the question in the positive rather than the negative: "Out of every 100 clients you screen for [method], how many, in your estimate, meet the eligibility criteria you mentioned above."

Figure 4.2: Mean Percent of Clients Not Meeting Individual Physician's Screening Criteria



Source: Survey of FP Practices of Private Physicians in Jamaica, 1993

Note: Calculations not weighted by physician's client load.

Clients seeking male sterilization are least likely to be turned away by physicians (34 percent of the physicians said that they had not encountered any clients who have not met the screening criteria), while those screened for the IUD are most likely not to meet all of the eligibility criteria. The average percent of clients that do not meet the screening criteria, as estimated by the physicians, is 12 percent for the pill, 15 percent for Depo-Provera, 18 percent for the IUD, 11 percent for female sterilization, and nine percent for male sterilization.

3. Parental consent required for teenagers

Providers were asked if they require parental consent for teenagers under 16 years of age to use family planning. Nearly half of the physicians indicated that they do require such consent (table 4.6). When asked what methods required consent, the physicians mentioned the pill (93 percent), Depo-Provera (80 percent), condom (26 percent), female barrier methods (45 percent) and IUD (84 percent).

Table 4.6
Parental Consent Required for Contraceptive Use, by Method for Private Physicians

Method	Percent Requiring parental permission
Yes	48.5
No	51.5
Number	(356)
Of those who answered yes, and provide the method:	
Pill	92.9
Depo-Provera	79.8
Condom	25.6
Female barrier	44.7
IUD	83.8

Note: Percentages may not add to 100 due to rounding.

When asked what they do if teenage clients do not have the parental consent to use a particular method of contraception, 24 percent of the physicians said they would suggest another method, while nearly one in five (19 percent) said they would provide the method anyway, as shown in table 4.7. Another 16 percent said they would not provide a method to the teenager, while 13 percent would try to convince the parents to allow their children to use contraception.

Table 4.7
Physicians Response for Teenage Clients Without Parental Consent

Response	Percent
Suggest another method	23.8
Provide method anyway	18.6
Do not provide any method	15.7
Convince parents to consent	12.8
Counselling/advice	10.5
Refer to another provider	8.1
Seek another person's consent	2.9
Counsel to abstain	0.6
Other	7.0
Number	(172)

Note: Percentages may not add to 100 due to rounding.

4. *Medical and laboratory tests required*

In addition to the eligibility criteria, private physicians were asked, *"Which exams and laboratory analyses do you routinely require before providing the following contraceptive methods?"* The purpose of this question was to study the clinic visits, exams and tests that clients undergo before using a contraceptive method. Table 4.8 lists the medical and laboratory tests required of clients for six contraceptive methods. The physicians were asked about each contraceptive method, but any tests they noted were mentioned spontaneously.

There is a wide range by method in the percent of providers who require tests prior to contraceptive use. For males seeking sterilization, for example, 68 percent of the physicians require tests, compared to 98 percent of the physicians who require tests for clients being screened for IUD use. Over half of the physicians say they take a clinical history and over 60 percent say they perform a complete physical exam before providing any of the contraceptive methods. Other common tests are weight, pelvic exam, pap smear and blood pressure. With the exception of female barrier methods, over 20 percent of the physicians require urine analysis before prescribing a contraceptive method. A smaller percent of the physicians require laboratory analysis of blood and STDs. Only a small percent of physicians require pregnancy tests prior to contraceptive use.

Table 4.8
Medical and Laboratory Tests Required Before Initial Use of Selected Contraceptive Methods.
(In percent)

Exam or test	Method					
	Pill	Depo-Provera	IUD	Female barrier method	Female sterilization	Male sterilization
None required	4.1	3.3	2.3	20.5	12.8	31.8
Number	(355)	(245)	(173)	(151)	(47)	(22)
Clinical history	63.8	61.6	57.4	57.5	61.0	53.3
Complete physical exam	84.1	84.8	79.3	73.3	87.8	60.0
Weight	51.5	50.6	36.1	40.8	46.3	13.3
Blood pressure	78.2	74.7	48.5	45.0	63.4	40.0
Breast exam	9.1	8.0	4.7	5.8	7.3	NA
Pelvic exam	59.4	63.3	76.9	72.5	73.2	NA
Pap Smear	54.4	54.9	60.9	46.7	36.6	NA
Lab analysis of blood	24.1	23.2	11.2	6.7	41.5	40.0
Lab analysis of urine	26.2	24.5	20.1	17.5	24.4	20.0
Lab analysis of STDs	7.6	6.8	18.3	7.5	2.4	13.3
Pregnancy test	2.9	3.4	4.1	--	7.3	NA
Other	10.9	9.3	10.1	3.3	2.4	60.0*
Number	(340)	(237)	(169)	(120)	(41)	(15)

Note: Percentages do not add to 100 because multiple responses were possible.

* Of the 15 physicians who require at least one exam before vasectomy, 27 percent require sperm analysis.

A small percent of the physicians in Jamaica say that they perform laboratory analysis of STDs before providing various contraceptive methods (ranging from two percent for female sterilization to 18 percent for the IUD).

The physicians were asked where clients go to get the laboratory tests. As shown in table 4.9, forty percent of clients are able to get the tests on site or within the greater facility. Of the 54 percent of clients who have to go elsewhere, 45 percent have to travel less than one mile, and an additional 34 percent go to a facility within one to five miles of the doctor's office.

Table 4.9
Location of Laboratory Tests for Clients

Location	Percent	
None required	6.1	
On site/within greater facility	40.0	
Elsewhere	53.9	
< one mile		44.8
1-5 miles		33.5
> 5 mile		14.4
other		7.2
Number	(367)	(194)

Note: Percentages may not add to 100 due to rounding.

B. Follow-up care

1. Follow-up schedules

Physicians were questioned about follow-up schedules they prescribe during the first and second years of pill or IUD use. They were asked, *"If no problems arise, how many follow-up visits are regularly scheduled for [method]?"* The purpose of this question was to find out how often clients are asked to return to the doctor's office for a follow-up visit. The results of this question are presented in table 4.10.

Table 4.10
First and Second Year Follow-up Visits for the Pill and IUD
(In percent)

Method	First Year	Second Year
Pill		
None	9.0	16.6
One	15.8	36.3
Two	23.9	22.5
Three	14.1	5.1
Four	25.6	6.8
Five or more	6.2	0.6
Varies/other	5.1	12.1
Average	2.7	1.4
Number	(355)	(355)

Method	First Year	Second Year
IUD		
None	4.4	12.6
One	24.2	45.1
Two	29.7	29.7
Three	13.2	3.3
Four	20.3	2.7
Five or more	5.5	0.5
Varies/other	2.7	6.0
Average	2.4	1.4
Number	(182)	(182)

Note: Percentages may not add to 100 due to rounding.

For the pill, nine percent of the physicians do not require a follow-up visit during the first year, compared to 17 percent in the second year. Because they do not require a visit does not mean that clients are not encouraged to return to the office if problems arise. Nearly 40 percent of the physicians require either one or two office visits during the first year, and 26 percent require four visits. Six percent of the physicians request that clients return for five or more visits during the first year of pill use. During the second year of use, nearly sixty percent of the physicians ask pill clients to return for one or two visits. The average number of visits for pill users is 2.7 in the first year and 1.4 in the second year.

During the first year of IUD use, four percent of the physicians require no follow-up visits. Nearly one-quarter (24 percent) of the physicians require only one follow-up visit, while 26 percent require four or more visits. As clients go into their second year of IUD use, the percent of physicians requiring no follow-up visit rises to 13 percent, and 45 percent of the physicians ask clients to return once during the year. An additional 30 percent of the physicians want their clients to return for two visits in the second year. Similar to the pill, the average number of IUD visits is 2.4 in the first year and 1.4 in the second year.

2. *Medical and laboratory tests required*

The physicians were asked what medical and laboratory tests they routinely conducted during follow-up visits for four contraceptive methods: pill, Depo-Provera, IUD and female barrier methods. For all methods, fewer physicians require tests during follow-up visits than before initial use of the method. As shown in table 4.11, the percent of physicians requiring no tests at follow-up ranges from 10 percent for IUD users to 31 percent for users of female barrier methods. Still, a large percentage of the physicians say they require a physical exam, check a client's weight, conduct a pelvic exam and take their blood pressure. On the whole, clients using

hormonal methods seem to be required to undergo more tests, but clients using the IUD are much more likely to be required to have a pelvic exam and a pap smear, followed by women using female barrier methods.

Table 4.11
Medical and Laboratory Tests Required During Follow-Up Visits for Use of Selected Contraceptive Methods.
(In percent)

Exam or test	Method			
	Pill	Depo-Provera	IUD	Female barrier methods
None required	13.8	11.4	10.4	31.1
Number	(355)	(245)	(173)	(151)
Physical exam	55.2	53.0	48.4	51.0
Weight	52.3	49.3	32.9	35.6
Pelvic exam	41.5	45.6	71.0	60.6
Blood pressure	75.8	75.1	41.9	44.2
Pap Smear	59.5	60.4	71.0	63.5
Urine	8.2	7.8	1.9	4.8
Breast exam	11.1	9.7	4.5	6.7
Hemoglobin/blood	7.8	8.8	3.2	1.0
Other	12.7	10.1	7.7	3.8
Number	(306)	(217)	(155)	(104)

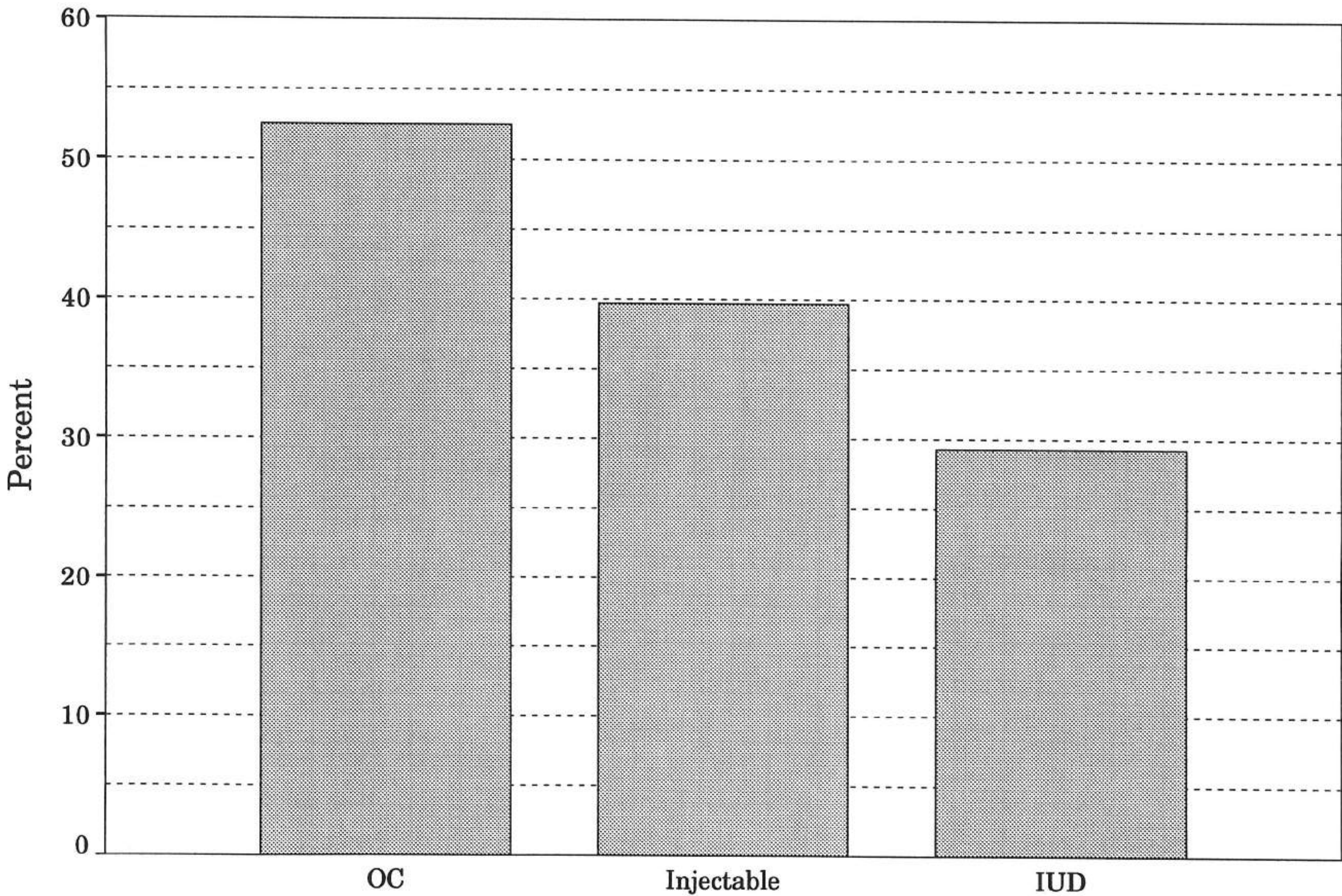
Note: Percents do not add to 100 because multiple responses were possible.

3. *Rest period from contraceptive use*

The physicians were asked, *"Are their any methods that you recommend clients to rest, or take a break from using?"* This question was followed by, *"Which methods do you recommend a rest from, and why?"*[5] Two-thirds (67 percent) of physicians indicated that they recommend a rest for at least one method. The three methods listed by the largest percentage of the physicians are

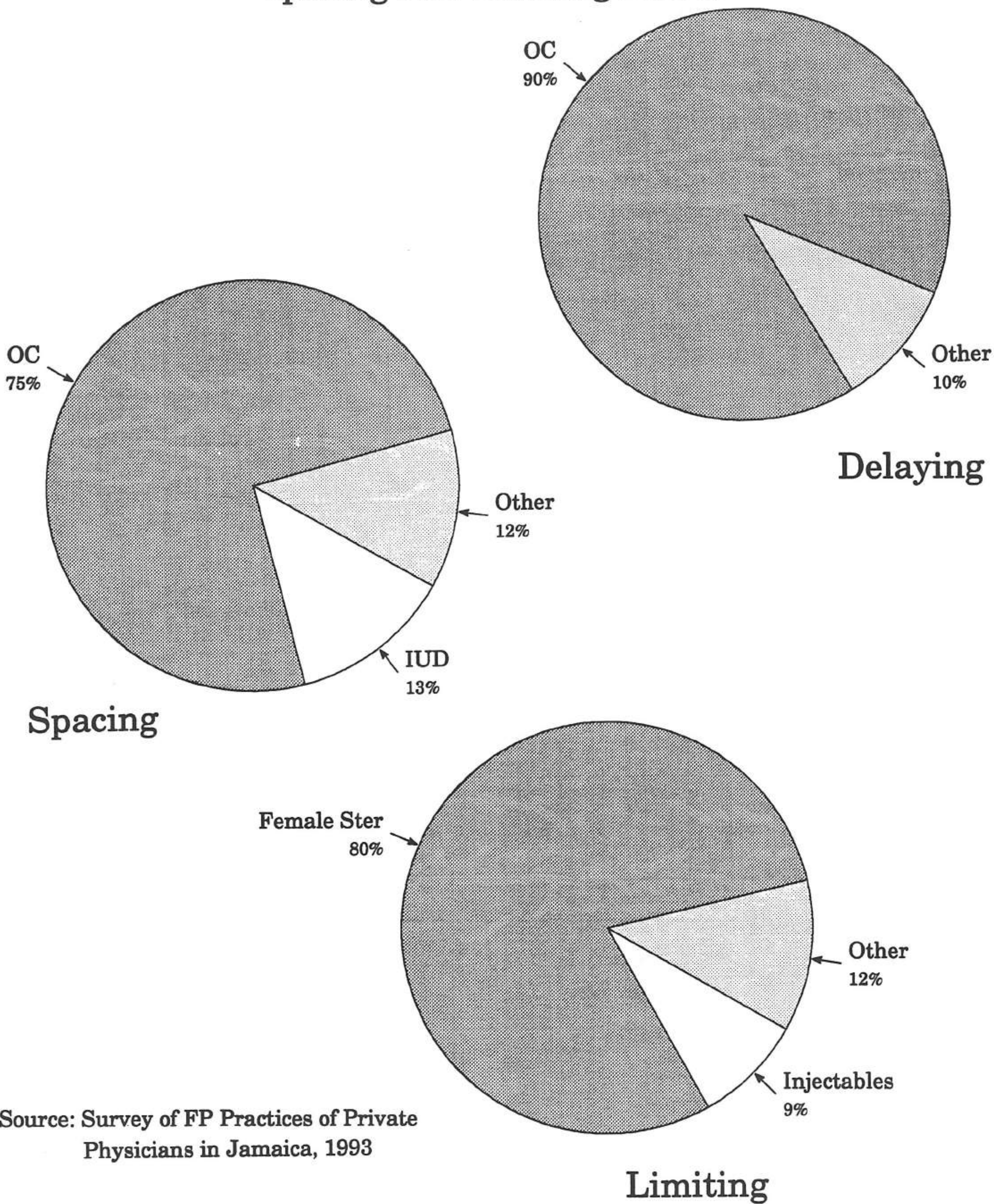
[5]This question might have better been asked, "For clients who are experiencing no medical problem or side effects while using [method] do you routinely recommend that the client take a break or have a rest from using [the method]?" This re-wording of the question would separate the immediate medical reasons for recommending a break (e.g. client has an infection or prolonged heavy bleeding) for the more routine reasons (e.g. to get hormones out of the system, to ensure fertility).

Figure 4.3: Percentage of Private Physicians Recommending a Rest Period from Specific Methods



Source: Survey of FP Practices of Private Physicians in Jamaica, 1993.

Figure 4.4: Preferred Methods for Delaying, Spacing and Limiting Births



Source: Survey of FP Practices of Private Physicians in Jamaica, 1993

two hormonal methods, the pill and Depo-Provera, and the IUD. As shown in table 4.12 and figure 4.3, more than one-half of all the physicians (53 percent) say they recommended a rest from the pill, followed by 40 percent of the physicians indicating a rest from Depo-Provera and 29 percent recommending a rest from the IUD. The reasons listed for the pill and Depo-Provera are similar; physicians worry about reactivating normal hormone flow and getting chemicals out of the system after three years, and about reducing complications and bleeding. Nearly one in 10 physicians who recommend a rest period from Depo-Provera do so to ensure a client's fertility. Reasons given to rest from the IUD are if the client has an infection (32 percent) and as a way to reduce the chances of PID or infection (22 percent).

Table 4.12
Rest Period Recommended and Reasons for Recommendation for Selected Contraceptive Methods
(In percent)

Rest recommended/ reason	Method		
	Pill	Depo-Provera	IUD
Yes	52.5	39.7	29.3
No	47.5	60.3	70.7
Number	(356)	(355)	(355)
If yes, reasons (in percent)			
Reactivate normal hormone flow	39.2	28.9	NA
Get chemicals out of body after 3 years	11.8	9.9	NA
Reduce complications/bleeding	21.0	31.0	9.8
Cardiovascular problems/hypertension/ thrombosis	6.5	--	--
Ensure fertility	--	8.5	--
Allow uterus to return to normal	--	--	8.8
Reduce PID/infection	--	--	21.5
If infection occurs	--	--	32.4
Other	21.4	21.8	21.6
Number	(186)	(142)	(102)

Note: Percentages may not add to 100 due to rounding.

C. Factors influencing method provision

1. Reasons to postpone provision

Physicians were asked, *"Are there any methods that you postpone the initial provision of for the following reasons?"* The reasons were not prompted so those listed in table 4.13 were spontaneously mentioned by the physicians. Three-quarters of the physicians say there is no reason to postpone the provision of male sterilization, followed by 56 percent who can think of no reason to postpone the provision of female sterilization. IUD users were the most likely clients to face a wait before the provision of that method; only 10 percent of the physicians say they have no reason to postpone provision of the IUD.

Nearly half of the physicians consider menstruation a factor in timing of provision of the female contraceptive methods, including sterilization. Breastfeeding of less than six weeks is a factor for use of some methods, mentioned by between 22 percent (for the IUD) to 81 percent (for the pill). For the female methods, waiting for the results of a pregnancy test is a reason to postpone the provision of the method for between one-quarter and one-third of the physicians.

Counselling is considered important for the timing of female and male sterilization, to ensure that the client has time to think about the method. The provision of an IUD would be postponed by only 49 percent of the physicians due to the presence of PID/STDs or an infection.

Lack of equipment or supplies is also considered a constraint by physicians in their provision of the contraceptive methods. For both the IUD and Depo-Provera, 34 percent of the physicians consider lack of supplies and equipment a reason to postpone the provision of those methods, compared to between 29 and 30 percent for male and female sterilization and 11 percent for the pill. This indicates that private physicians encounter shortages of equipment and supplies in their provision of methods.

Table 4.13
Reasons to Postpone Provision of Selected Contraceptive Methods
(In percent)

Reason	Method				
	Pill	Depo-Provera	IUD	Female sterilization	Male sterilization
No reason	17.1	20.1	10.2	56.0	75.0
Number	(356)	(249)	(176)	(50)	(24)
Menstruation	46.6	48.0	65.6	54.5	NA
Breastfeeding < 6 weeks	80.9	68.2	22.3	NA	NA
Breastfeeding >= 6 weeks	27.2	19.9	3.2	NA	NA
Lack of supplies/equipment	10.7	33.8	34.4	30.0	28.6
Parental consent	35.6	27.9	28.0	23.8	NA
Number	(298)	(201)	(157)	(20)	(7)
Respondent listed unprompted reasons	14.8	15.1	22.3	42.9	85.7
Pregnancy test	25.0	33.3	22.9	25.0	NA
PID/STD/infection	18.2	6.7	48.6	--	--
Pap Smear	6.8	6.7	2.9	--	NA
Dysfunctional bleeding	4.5	10.0	5.7	--	--
Migraine	6.8	--	--	--	--
Fibroids	--	--	--	12.5	NA
Time to think about method	6.8	6.7	2.9	5.0	40.0
Counselling	2.3	3.3	2.9	12.5	20.0
Other	29.6	33.2	14.3	25.0	40.0
Number	(44)	(30)	(35)	(8)	(5)

Note: Percentages do not equal 100 because multiple responses were possible.

The physicians were then asked, *"What do you do if you postpone the provision of a method?"* Up to two responses from the physicians are shown in table 4.14. The overwhelming first choice of the physicians is to provide another method (mentioned by 82 percent), followed by telling the client to return later (30 percent), and referring the client to another provider (14 percent). Thus, it is possible that nearly two in ten clients may not be getting another contraceptive method to use during the postponement period.

Table 4.14
Response by Private Physicians if Postpone Provision of Method

Response	Percent
Provide another method	81.5
Tell client to return later	30.1
Refer to another provider	13.8
Counsel to use another method	6.0
Advise abstinence	3.4
Treat condition that exists	0.9
Other	0.3
Number	(319)

Note: Percentages do not equal 100 because multiple responses were possible.

2. *Preference for and opposition to methods*

In order to understand the preferences private physicians have for particular contraceptive methods, they were asked which methods they tended to prefer for clients wishing to delay, space or limit childbearing. The results are shown in table 4.15 and figure 4.4. Providers show a strong preference for the pill, both for delaying and spacing childbearing (90 percent for delaying and 75 percent for spacing). An additional 13 percent of the physicians prefer the IUD for spacing. For limiting childbearing, the choice is female sterilization, mentioned by 80 percent of the physicians. The physicians' responses for IUDs are surprising given the anecdotal assumption in Jamaica that the IUD is unpopular among providers and clients alike.

Table 4.15
Preferences by Private Physicians For Methods
For Clients Wanting to Delay, Space and Limit Childbearing
(In percent)

Method	**Delay**	**Space**	**Limit**
Pill	90.1	74.7	3.0
IUD	2.5	12.9	5.8
Depo-Provera	--	4.7	8.5
Condom	4.1	2.5	--
Female sterilization	--	--	79.7
Other	3.4	5.2	3.1
Number	(364)	(364)	(364)

Note: Percentages may not add to 100 due to rounding.

The physicians were then asked why they preferred the method(s) they mentioned. Tables 4.16 to 4.18 show the results for delaying, spacing and limiting childbearing, respectively.

a. Delay

Physicians prefer the pill for delaying childbearing because it is most effective (36 percent), safe (35 percent), and has the least side effects (29 percent). An additional 17 percent say it is easy to use, while 16 percent say it is the most acceptable method. The condom was mentioned by nine physicians because it has the least side effects (67 percent), and it is safe (33 percent). Providers who prefer the IUD do so because they say it has the least side effects (50 percent), it is the most effective (38 percent), and it is safe (25 percent).

Table 4.16
Reasons for Preference for Methods to Delay Childbearing by Private Physicians
(In percent)

Reason	Method		
	Pill	Condom	IUD
Least side effects	28.8	66.7	50.0
Safe	35.1	33.3	25.0
Most effective	35.8	--	37.5
Not too expensive	3.0	11.1	--
Most acceptable	15.9	11.1	--
Most professional experience with method	4.6	--	--
Easy to use	16.9	--	--
Little discontinuation	4.0	--	12.5
Best method	0.3	--	--
Client with STDs	--	11.1	--
Compliance	0.7	--	--
Doesn't qualify for another method	0.3	--	--
Easily reversible	10.3	--	--
Non-hormonal	--	--	12.5
Preference	0.3	--	--
Woman has control	0.3	--	--
Other	2.0	--	12.5
Number	(302)	(9)	(8)

Note: Percentages do not equal 100 because multiple responses were possible.

b. Space

For clients seeking to space childbirth, providers who prefer the pill or IUD do so for the same reasons mentioned above, namely efficacy, safety, least side effects, ease of use, and acceptability to clients, as shown in table 4.17. A few providers prefer Depo-Provera, because it is most effective, easy to use, and is safe. Those physicians who prefer the condom do so because they say the condom has the least side effects, is the safest method, is most effective, not too expensive and is most acceptable.

Table 4.17
Reasons for Preference for Methods to Space Childbearing by Private Physicians
(In percent)

Reason	Method			
	Pill	IUD	Depo-Provera	Condom
Most effective	39.4	38.2	42.9	14.3
Safe	35.0	14.7	21.4	42.9
Least side effects	28.1	17.6	--	71.4
Easy to use	17.2	20.6	28.6	--
Most acceptable	14.3	11.8	7.1	14.3
Easily reversible	6.9	8.8	--	--
Most professional experience with method	6.4	2.9	7.1	--
Little discontinuation	3.0	14.7	7.1	--
Not too expensive	2.0	5.9	--	14.3
Compliance	1.5	2.9	7.1	--
Chance to change mind	0.5	--	--	--
Practical	--	5.9	--	--
Other	5.4	11.7	--	7.1
Number	(203)	(34)	(14)	(7)

Note: Percentages do not equal 100 because multiple responses were possible.

c. Limit

For clients who want to limit childbearing, the largest percent of physicians who choose female sterilization do so because they consider the method the most effective, as do 75 percent of the 14 physicians who choose Depo-Provera, and 50 percent of the eight who choose the IUD (see table 4.18). Over half (57 percent) of the seven physicians who choose the pill do so because they perceive the pill as easy to use.

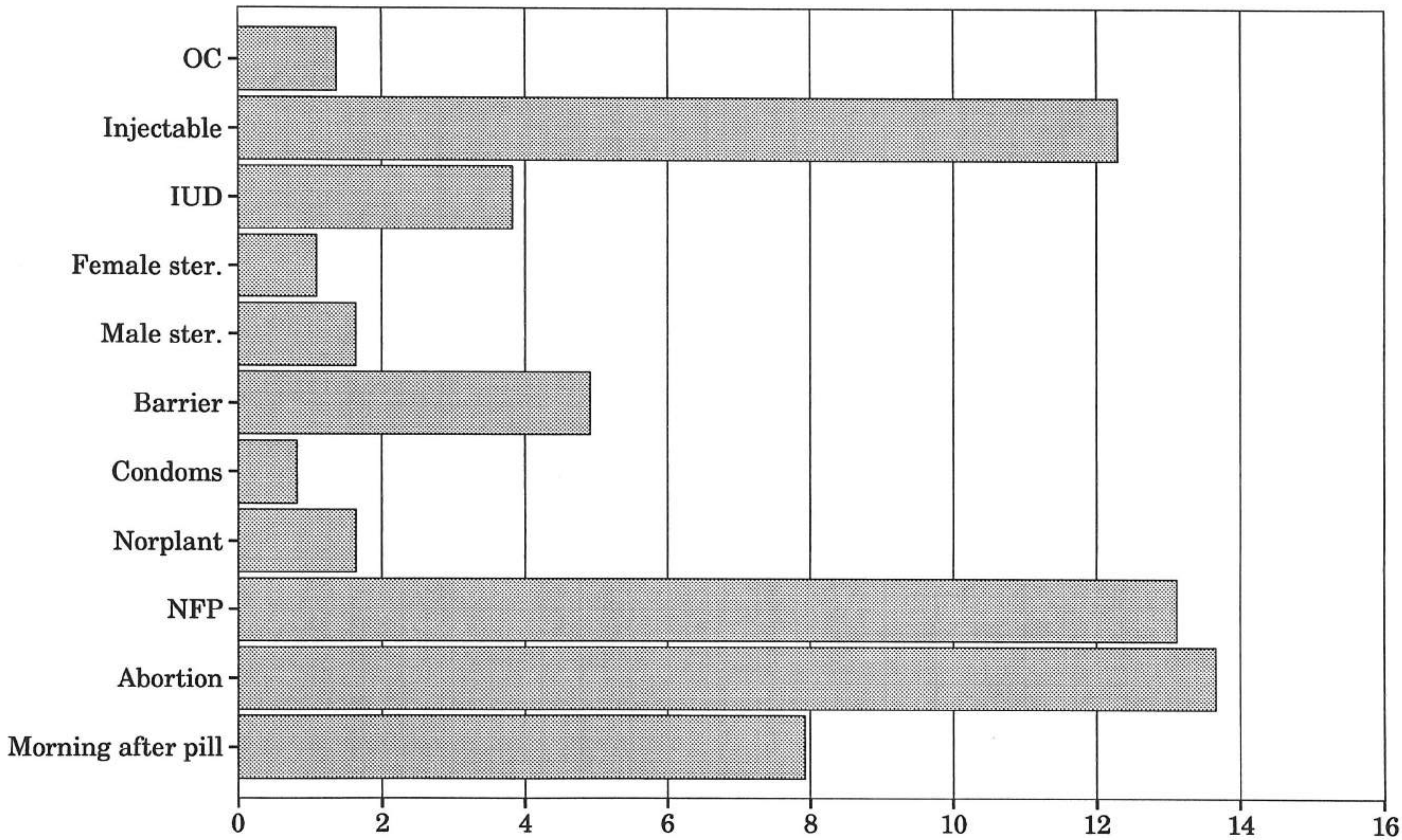
Table 4.18
Reasons for Preference for Methods to Limit Childbearing by Private Physicians
(In percent)

Reason	Method			
	Female sterilization	Depo-Provera	IUD	Pill
Least side effects	7.3	12.5	--	--
Safe	17.4	--	12.5	33.3
Most effective	60.0	75.0	50.0	14.3
Most acceptable	5.8	12.5	--	28.6
Most professional experience with method	1.5	12.5	12.5	--
Easy to use	1.5	--	--	57.1
Little discontinuation	9.3	--	12.5	--
Easily reversible	NA	--	--	14.3
Non-hormonal	1.2	--	12.5	--
Permanent	14.3	--	--	--
Other	2.3	5.9	12.5	14.3
Number	(259)	(8)	(8)	(7)

Note: Percentages do not equal 100 because multiple responses were possible.

Finally, the providers were asked if there were any contraceptive methods that they were opposed to and, if so, for what reasons. The results are presented in table 4.19 and figure 4.5. Nearly half (40 percent) of the providers profess to being opposed to at least one method. More than 1 in 10 of all physicians cite each cite opposition to Depo-Provera (12 percent) and natural family planning (13 percent). Although abortion is not a family planning method, but rather is used to regulate fertility in cases of unwanted pregnancy, 14 percent of the physicians spontaneously reported opposing abortion. An additional 5 percent said they are opposed to female barrier methods.

Figure 4.5: Opposition to Family Planning And Fertility Regulation Methods



Source: Survey of FP Practices of Private Physicians in Jamaica, 1993

Table 4.19
Opposition to Selected Contraceptive Methods* by Private Physicians
(In percent)

Method	Percent
Opposed to at least one method	40.2
Number	(366)
Of those who are opposed to a method:	
Natural family planning	13.1
Depo-Provera	12.3
Female barrier methods	4.9
IUD	3.8
NORPLANT®	1.6
Male sterilization	1.6
Pill	1.4
Female sterilization	1.1
Condom	0.8
Abortion*	13.7
Morning after pill*	7.9
Number	(366)

Note: Percentages do not equal 100 because multiple responses were possible.

* Abortion and the morning after pill are not considered methods of family planning, but are noted here because they were mentioned by the providers.

Providers mentioned a variety of medical and social reasons for opposing various methods of contraception, as shown in table 4.20. The largest numbers of private physicians noted their opposition to abortion; of these 50 opposing physicians, 70 percent cited moral reasons and the fact that abortion is illegal. Forty-eight physicians are opposed to natural family planning; 90 percent cited the high failure rate. Forty-five physicians disapprove of Depo-Provera; they are equally divided between thinking that Depo-Provera has too many side effects and is unsafe (24 percent) and believing that the method causes bleeding (22 percent.) Fewer (16 percent) worry about fertility problems after using Depo-Provera or long-term damage from the method. Twenty-nine physicians say they are opposed to the morning after pill, because of side effects (14 percent), because women abuse the method (14 percent) or because they perceive the morning after pill as morally wrong and illegal (11 percent.)

Table 4.20
Reasons for Opposition to Selected Contraceptive Methods by Private Physicians
(In percent)

Reason	Method					
	Pill	Depo-Provera	IUD	Female sterilization	Male sterilization	NORPLANT®
Medical						
Bleeding	20.0	22.2	--	--	--	--
Causes infection	20.0	2.2	35.7	--	--	--
Complications	--	4.4	--	--	--	--
Effects on uterus	--	2.2	--	--	--	--
External substance	--	--	7.1	--	--	--
Fertility problems after removal/ long-term damage	--	15.5	--	--	--	--
Hormonal content	--	2.2	--	--	--	16.7
High failure rate	--	--	7.1	--	--	16.7
Abortifacient	--	--	21.4	--	--	--
Once in system cannot remove	--	4.4	--	--	--	--
Too many side effects/unsafe	20.0	24.4	14.3	--	16.7	--
Unnecessary surgery side effects	--	--	--	--	16.7	--
Weight gain	20.0	2.2	--	--	--	--

Reason	Method					
	Pill	Depo-Provera	IUD	Female sterilization	Male sterilization	NORPLANT®
Social						
Do not like it	--	6.7	7.1	--	--	--
Difficulty in counselling	--	2.2	--	25.0	--	--
Uncertainty about side effects	--	11.1	--	--	--	16.7
Morally wrong/religious opposition/ illegal	--	2.2	14.3	--	--	--
Other	40.0	15.5	7.1	100.0	83.3	66.7
Number	(5)	(45)	(14)	(4)	(6)	(6)

Note: Percentages do not equal 100 because multiple responses were possible.

Table 4.20
Reasons for Opposition to Selected Contraceptive Methods by Private Physicians--continued
(In percent)

Reason	Method				
	Female barriers methods	Condom	Natural family planning	Abortion	Morning after pill
Medical					
Causes infection	5.6	--	--	--	--
Complications	--	--	--	4.0	3.6
External substance	5.6	--	--	--	--
High failure rate	66.7	100.0	89.6	2.0	39.3
Too many side effects/unsafe	--	--	6.3	6.0	14.3
Social					
Women abuse it	--	--	--	2.0	14.3
Client ignorance	5.6	--	6.3	--	--
Do not like it	5.6	--	2.1	6.0	3.6
Messy	27.8	--	--	--	--
Morally wrong/religious opposition/ illegal	--	--	--	70.0	10.7
Other	11.1	--	2.1	14.0	21.4
Number	(18)	(3)	(48)	(50)	(29)

Note: Percentages do not equal 100 because multiple responses were possible.

SECTION III.

THE SOCIAL AND HEALTH CONTEXT OF REPRODUCTION, AND QUALITY OF CARE

Chapter 5: The Social and Health Context of Reproduction, and Quality of Care

"Family planning is necessary. Doctors need to gain more knowledge so it can be imparted to their clients."

Private physician, Jamaica

Recent years have witnessed increasing concern for quality of care in family planning because most researchers and service providers have begun to realize that when contraceptive methods are delivered without maintaining high quality levels, continuation rates are usually low and the image of the methods and services in impaired.

There is not widely accepted definition of quality of services in family planning because quality includes subjective components and changes over time, and is greatly influenced by the social and cultural environment.

In order to understand some of the practices of private physicians in Jamaica, it is important to examine the social context in which reproduction occurs in Jamaica, as well as the underlying health situation in the country, particularly as it relates to reproduction.

A. Social and health context of reproduction

1. The social context

The social context of reproduction in Jamaica can be characterized as one in which, particularly among the poor, sexual intercourse begins at an early age, with a series of "visiting" relationships. These usually give way to common law unions and, perhaps ultimately, to legal marriages. None of these unions ensure fidelity on the part of males. Parenting with multiple partners is common. Sixty-three percent of women aged 15-19 reported sexual experience in the CPS; by age 20-24, fully 93 percent of women had sexual experience (NFPB, 1993). Of those women aged 15 to 45 in union, 19 percent were married, 35 percent were in a common law union and 46 percent had a visiting partner.

Many women are employed in marginal occupations--domestic service, informal trading, field labourers--and receive little more than subsistence wages. Many see their material welfare, therefore, as dependent on access to men's wages and childbearing as essential to continued support.

a. Relationship patterns

Relationships between men and women in Jamaica are generally regarded as tenuous. According to Chambers and Branche, who conducted a series of focus group discussions in 1993, men conceive of their lives independently from their partner, even from women they might be involved with at the time. Men perceive a lifetime of potency with an unending ability to start new relationships. Yet, they desire control, including control over family planning methods that their partners use; they do not think highly of vasectomy for themselves. In-depth analyses of reproductive patterns in Jamaica confirm that these patterns of unions and relationships between men and women have been extant in the country for many years (Blake, 1961; Stycos, 1968; Roberts and Sinclair, 1978; Bailey et al., 1988.).

The old patterns may be beginning to shift, at least in urban areas of Jamaica (Chambers and Branche, 1994). Some urban women want to establish their independence from men, as they have come to realize that men are not generally reliable in a relationship. Roberts and Sinclair (1978, pp. 248-249), however, reported that women may not feel that visiting unions are detrimental to their security. They found that a woman only entered into marriage "when she is firmly convinced that such a course of action will prove of positive benefit to her and to her children."

b. The value of fertility

Children are believed to help cement relationships, and thus fertility is highly valued. Childless women must face the stigma in Jamaica of being considered "mules" (the sterile cross between a horse and donkey). In an analysis of voluntary and involuntary childlessness conducted with World Fertility Survey data, Poston et al., (1983) found that, as in other countries, 96 percent of the permanently childless women in Jamaica were not childless by choice. Respondents in a study by Roberts and Sinclair (1978), who were asked about childlessness, expressed compassion towards women who could not have children and noted how hard it would be to be childless.

This societal emphasis on fertility, combined with the accepted patterns of relationships, results in actual family size exceeding desired family size for some women. Indeed the 1993 CPS noted that 76 percent of births were either unwanted or mistimed (NFPB, 1993). In a study of sterilization in Jamaica, Bailey et al. (1988, p. 622) note that "women may not want additional children but they want the stability which, they believe, a child may bring." The 1993 CPS found that desired family size for women was 2.8 children, while the average number of children ever born to women was 1.8 (NFPB, 1993). However, the mean number of children reported by women aged 35-39 was 3.3 children and the women in the 40-44 age group had an average of 4.1 children.

It is not clear whether the pattern of unions in Jamaica serves, in the long run, to increase or decrease fertility. On the one hand, use of family planning is high and exposure to intercourse is reduced due to the time spent in transition between various unions. On the other hand, men

and women feel the desire to produce children in each union, thus increasing fertility beyond a woman's desired family size, depending on the number of relationships she is involved in over time.

c. Knowledge of the reproductive cycle

Knowledge of the reproductive cycle, menstruation and the role of intercourse in procreation is limited in Jamaica. A study conducted by Roberts and Sinclair (1978) found that 82 percent of the women had no knowledge of the menstrual cycle; only 5 percent of the women had a satisfactory understanding of the menstrual cycle. One-third of the women were not aware of the relationship between intercourse and reproduction, and an additional third of the sample were aware but did not understand the mechanics of the relationship. In another study, Jamaican women were asked to draw the female reproductive system. There was a common notion among the women that the reproductive system was a single tube, open at both ends (MacCormack, 1985). The 1993 CPS found that only 30 percent of women and 13 percent of men knew when during the menstrual cycle a women is most likely to get pregnant (NFPB, 1994).

While knowledge of the reproductive cycle is limited, women perceive menstruation as a cleansing process and as an indicator of health. According to MacCormack (1985, p. 285)) "Jamaican women are interested in their reproductive health, and monitor the state of their health by noting the time, quantity and quality of menstrual bleeding." This view of menstruation may have significant implications for the acceptability of contraceptive methods that tend to alter menstrual flow, such as injectables and NORPLANT®.

2. *The health context*

Jamaican physicians provide contraceptives within a health environment different than in many other places. The leading causes of hospitalization for women in the country include the following:

- Complications of pregnancy
- Cardiovascular diseases
- Diseases of the genito-urinary system
- Breast and cervical cancer
- Diabetes mellitus
- Perinatal conditions (McCaw-Binns, 1993).

Jamaica and the Caribbean are known as areas with high rates of hypertension, diabetes mellitus and cervical cancer, (table 5.1), all conditions of concern when providing contraceptive care. With rates double those in the United States, hypertension is of particular concern to health care providers in the country. It has been speculated that the high incidence of these conditions in

Jamaica and the rest of the Caribbean is due to a combination of genetic and environmental factors; treatment for hypertension in black patients differs from that in white patients (Nicholson, 1985).

Table 5.1 Death Rates for Hypertension, Diabetes Mellitus and Cervical Cancer, for Women in Jamaica and Selected Countries (per 100,000 women)

Country	Year	Hyper-tension	Diabetes mellitus	Cervical cancer
Jamaica	1984	38.0	37.2	12.8
Trinidad and Tobago	1986	18.8	77.7	9.3
Barbados	1988	34.0	85.8	19.2
North America	1987	14.0	17.9	3.5

Source: PAHO, 1990. Health Conditions in the Americas. Washington, DC: PAHO/WHO.

Hypertension is treated as a disease in the Caribbean rather than as a risk factor for other diseases. According to a 1987 report, "it must be recognized at the outset that unlike the situation in Europe and North America 'Heart Disease' in adults in the Caribbean is predominantly the end result of undiagnosed, uncontrolled, or inadequately treated hypertension." The major problems associated with hypertension among the black population in the West Indies include renal impairment, cardiac failure and stroke. However, in general no underlying preventable cause is found in most hypertensive patients. One contributing factor to the high mortality associated with hypertensive disease is that the disease in most patients remains either untreated or inadequately treated until complications occur (Grell, 1987).

Diabetes mellitus, exacerbated by protein energy malnutrition, is also prevalent in Jamaica (Morrison, 1983). In a study of Jamaican patients with diabetes, knowledge of the disease and its treatment was low (57 percent of the patients had poor knowledge ratings). Most patients did not consider their diabetes serious until they experienced severe complications, therefore their cues for action were inadequate (Alleyne, et al., 1991.)

While not as high as in Barbados, the death rate for cervical cancer is three times higher in Jamaica than in the United States. In a 1974 pilot study screening for cervical cancer, "the prevalence of preclinical carcinoma was 3-6 times that observed in such schemes carried out in North America and Europe, but was essentially similar to those of other Commonwealth Caribbean territories" (Persaud, 1974).

Sickle cell disease is also of concern in Jamaica, as in other black populations. One study found that women with sickle cell disease, rather than being sub-fertile as previously thought, generally

start childbearing a couple of years later, on average, than do other women in Jamaica (Alleyne, et al., 1981). This and a later study (Poddar et al., 1986) found higher rates of fetal wastage among women with sickle cell disease than among other women.

3. *Consumers' views of contraceptives*

Two studies provide a picture of consumers' views of contraceptives and their effect on the body, giving insight into the practices of service providers in giving contraceptive methods to women. The findings show that women have many misconceptions about contraceptive methods. According to MacCormack (1985, p. 281), "Worries about altered menstruation, irreversible sterility and other consequences of contraception contributed to underutilization of services." According to Chambers and Branche (1994, p. 7), "Family planning decisions are complicated by the nature of relationships. Multiple partners, casual encounters, and uncertain futures stalk almost every relationship. Men talk about them, and women use the information for their planning--always remembering who will carry the burden of childbearing and rearing."

The Pill. Some women in MacCormack's study (1985) believed that pills work mechanically to block sperm through a build-up of the pills in the tubes. The women believed that a periodic rest from the pill was necessary to reduce the build-up of the pills. The pill was also perceived by some women to cause clots (that affect the menstrual period). According to Chambers and Branche (1993), the pill is considered the "best of the worst" option for contraception. The pill is seen as the method to start one's contraceptive career, and as the method most widely suggested by doctors. Women worried about the side effects associated with the "drug" in the pill, both for their general health and future child-bearing ability. In 1993, 23.7 percent of women aged 15-45 who are in a union use the pill (NFPB, 1993).

Depo-Provera. Women worry about the lack of bleeding associated with long-term use of Depo-Provera. With amenorrhea, women do not get the benefit of a "good wash-out" associated with menstruation. They think that an accumulation of blood can cause high blood pressure (a worry in a country where hypertension is pervasive), or that it blocks up the tubes and causes infertility (MacCormack, 1985). Focus group discussions in 1993 also found that some women worried about the strength of the injection. A three month injection of contraception was considered too strong a dose to have in the body (Chambers and Branche, 1994). Women in the focus group discussions indicated that their attitudes were heavily influenced by nurses at the health centers. In 1993, 6.4 percent of women aged 15-45 who are in a union use Depo-Provera (NFPB, 1993).

IUD. Women in Jamaica know about IUDs, but consider them "unidentified foreign objects," that suffer from a poor reputation. According to Chambers and Branche (1994, p. 29), "Doctors are also implicated. They rarely recommend usage." MacCormack (1985) found that women who considered the reproductive system a tube worried that the IUD would drift up the tube and get lost in the body. Additionally, women worried that the IUD causes pain and pelvic infection which might lead to blocked tubes and infertility. The IUD was considered to cause pain for the

user and her partner and be unreliable due to spontaneous expulsion. In 1993, 1.1 percent of women aged 15-45 who are in a union use the IUD (NFPB, 1993).

Tubal ligation. Women in MacCormack's (1985) study talked a lot about their tubes and the need to keep them open. With the view that the reproductive system is one long tube, the tube was sometimes considered the same as the vagina, so 'having one's tubes tied' was interpreted as having the vagina tied, and subsequently no more sex. In the 1993 focus group discussions, women considered the idea of permanent contraception daunting; such actions run counter to the nature of relationships in the Jamaican environment (also see Bailey et al., 1988). Tubal ligation is well known and highly regarded, however its use is highly correlated with age and stability of relationship. In 1993, 13.4 percent of women aged 15-45 who are in a union had a sterilization (NFPB, 1993).

Condoms. As knowledge of AIDS/STDs becomes more prevalent in Jamaica, use of condoms is increasing, however, consumers still do not like the method. Condoms are perceived to protect against disease and are convenient and necessary for most short term and "outside" relationships. According to Chambers and Branche (1994, p. 16), "although men recognized a need for the condom in this era of AIDS, there was no guarantee that they would be used." In 1993, 17.9 percent of women aged 15-45 who are in a union used condoms (NFPB, 1993).

It is within this social and health context that private providers in Jamaica offer family planning methods to users. The findings in chapter 4 indicate that the practices of the physicians are influenced by the health conditions of users, particularly the high incidence of hypertension in the population, and the incidence of diabetes mellitus, and cervical cancer. Service practices are also likely affected by the social context of reproduction, including the likelihood that clients have multiple partners. Opinions of the physicians on contraceptive methods are likely affected by the social view of menstruation and the value of fertility.

B. Quality of care and service delivery practices

In recent years, family planning programme managers and researchers have used several conceptual frameworks to examine and assess family planning services. For example, Judith Bruce proposed a quality of care model that evaluates family planning services from the clients' perspective. Her framework distinguishes six elements of quality: choice of methods for clients, information clients receive, provider-client interaction, technical competence of providers, continuity of care received by clients, and appropriateness and acceptability of services for clients (Bruce, 1990). In 1992, Shelton et. al. suggested a different approach for assessing family planning services: "medical barriers" to contraceptive access.

Shelton et. al., (1992), medical physicians with years of experience in family planning worldwide, defined medical barriers as "dysfunctional practices derived at least partially from a medical rationale which result in a scientifically unjustifiable impediment to, or denial of, contraception."

They identified six types of medical barriers as: regulatory obstacles, types of providers who can provide methods, process and scheduling hurdles, inappropriate contraindications, eligibility criteria, and provider bias. Shelton later identified inappropriate management of side effects as an additional medical barrier (Shelton et. al., 1992; Shelton, 1993). According to Shelton et al., (1993, p. 1335), "some individuals might argue that what we call medical obstacles are examples of good quality care....we agree that many clinical practices both help to make the best contraceptive choice and provide secondary health benefits such as screening for [sexually transmitted diseases] STDs. The challenge is to separate the wheat from the chaff."

This study of private physicians in Jamaica steps beyond a narrow definition of medical barriers to examine service delivery practices. Family planning service delivery practices of providers are based on five factors:

1. Training received (both basic and refresher),
2. Service delivery guidelines and protocols guiding work,
3. Practical experience gained over years of work,
4. Personal preferences and biases (often influenced by socio-cultural factors); and
5. Resources (e.g. equipment, supplies, and contraceptive commodities) available for the provision of care.

These five factors combine to influence the quality of care that clients receive. Providers will be affected differently by the five factors (Hardee, et al., 1994).

Because contraceptive methods have been made safer over the past 30 years, an important step in improving quality of care is to examine service policies and provider practices to ensure that they are based on current scientific information. Many prescribing practices for contraceptives are based on outdated information, or were devised for contraceptives that have since been reformulated (King et. al., 1993).

The design of service guidelines is "the step that converts all the accumulated research, development, and experience into practical recommendations that largely determine what happens to patients" (Eddy, 1990; Calla, 1992). According to Cohen et al. (1982, p. 1044), "Much of current medical practice is based upon precedent alone...consequently we frequently observe high utilization of interventions of questionable efficacy, while those of demonstrated value may be underutilized." At issue, however, is the lack of consistency, even among international experts and organizations, on service delivery guidelines (WHO, 1992; Adrian et al., 1992; Angle et al., 1993). While there is wide agreement on most practices, the need for some practices continues to be debated (Guidelines Working Group, 1994).

A research focus on service practices will help to distinguish between service guidelines and practices that are medically necessary and those that may not be necessary, and will also highlight practices that are perhaps being neglected, but that are essential to the safe provision of contraception (Hardee et al., 1994). The Jamaican family planning programme should choose the guidelines it will follow, basing the decision on current service practices, available resources, perceived trade-offs, and the goals and objectives of the programme.

SECTION IV.

COMPARISON OF PRACTICES AND GUIDELINES, CONCLUSIONS AND RECOMMENDATIONS

Chapter 6: Scientific Evidence and Service Guidelines

"Doctors need consistent information on new advances in contraception."

"Whatever programme is designed, we need to weigh the positive aspects. Pregnancy can kill; I have never seen any family planning method that causes any serious harm. We need to address the misconception that family planning will kill them."

Private Physicians, Jamaica

In this chapter, the practices of private providers are compared, where possible, with the Jamaican *Family Planning Service Delivery Manual* (MOH and NFPB, 1991), and with international guidelines. The Guidelines for Clinical Procedures in Family Planning of the Program for International Training in Health were most extensively used in this review[6] (INTRAH, 1993), Again, it is important to note that private providers were not an intended audience for the Jamaican guidelines and were not expected to be aware of the INTRAH guidelines. The purpose of this comparison is to present Jamaican service delivery practices in relationship to current international evidence on the safe provision and use of contraception.[7]

A. Service delivery guidelines

Service delivery guidelines can play an important role in standardizing the care that clients receive from service providers in a country. By outlining recommended practices for the provision of contraceptive methods, the guidelines can help doctors provide consistent care to clients. By reviewing and revising the guidelines periodically based on new scientific information, and by providing refresher training to providers, family planning programs can help assure that clients are provided high quality contraceptive care.

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[6]INTRAH guidelines were extensively reviewed by experts in 13 countries in North America, Europe, Africa, and Asia. The guidelines are accompanied by extensive citations to support the various recommended service practices. The INTRAH guidelines were chosen for comparative purposes because they are widely considered the most current and comprehensive service delivery guidelines available.

[7]Another group, the Guidelines Working Group of the U.S. Agency for International Development, is in the process of developing "Consensus Guidance for Updating Practices: Hormonal Methods and IUDs" (1994). When finalized later in 1994, the guidelines, currently in draft, will also be available as a resource for Jamaican service providers.

The Ministry of Health and the National Family Planning Board developed national service delivery guidelines for family planning in 1991 (MOH and NFPB, 1992). The guidelines, titled *The Family Planning Service Delivery Manual*, represent a revision of the family planning component of the Maternal and Child Health Norms, a Ministry of Health publication. These guidelines, developed primarily for use in the public sector, include chapters on counselling, physical assessment, breast examination and pap smear. The contraceptive methods covered include oral contraceptives, injectables, NORPLANT®, IUD, barrier methods and natural family planning. In addition, there are chapters on contraception for adolescents and breastfeeding and contraception. The manual also includes a list of equipment needed in a family planning clinic, ideas for monthly reporting, and management of supplies. Separate guidelines are available for the provision of male and female sterilization.

The physicians were asked if they are aware of any national guidelines for the delivery of family planning. Due to funding constraints, the guidelines were not widely disseminated to public sector providers, nor were they targeted to the private sector. It is not surprising, then, that only 25 percent of the physicians know of the service delivery guidelines (table 6.1). Some of the physicians mentioned that they would like to know more about the guidelines. When asked if they use the manual, 27 percent of those who knew about it said they use the manual. When asked why they do not use it, 62 percent replied that they do not have a copy, while an additional 28 percent said they already know the information.

Table 6.1
Private Physicians' Knowledge and Use of Public Sector Service Delivery Guidelines

Item	Percent
Know manual exists	
Yes	25.5
No	40.5
Do not know	34.0
Number	(365)
Uses Manual (of those knowing it exists)	
Yes	27.2
No	72.8
Number	(92)
Why does not use it (of those knowing it exists)	
Do not have a copy	61.5
Already know the information	27.7
Other	10.8
Number	(65)

Note: percentages may not add to 100 due to rounding.

B. Initial provision of services

1. *Eligibility criteria for contraceptive use*

a. Age criteria

Jamaica's service delivery guidelines do not specify age requirements for contraceptive use. However, age is implied: "A general rule for hormonal contraceptive use in adolescence is that they should not be used if menarche is less than two (2) years" (MOH and NFPB, 1991: 37). In addition, if a woman is "over 40 and has any risk factors for cardiovascular disease," she should not use OCs. International evidence does not indicate age requirements for contraceptive use (except for women over 35 with other contraindications (Guillebaud, 1992; Hatcher et al., 1989; INTRAH, 1993). Most physicians in Jamaica apply a minimum age of 16 for the pill and a maximum age of 35 years. International guidelines acknowledge, however, that for voluntary surgical contraception (VSC), "local guidelines may specify a minimum age...for men or women to qualify for VSC" (INTRAH, 1993:208).

b. Parity criteria

Jamaican service delivery guidelines state that Depo-Provera is a method for "women [and adolescents] who have at least one child," and that "fertility must be proven so that delay in return to fertility can be established" (MOH and NFPB, 1991: 38,54). INTRAH, Contraceptive Technology International (CTI), and IPPF guidelines do not specify a parity requirement for Depo-Provera, although it is important for young and nulliparous women to understand the increased delay in return to fertility, which is seven months, on average (MBGWG, 1994; Mishell et al., 1991).

For use of the IUD, the Jamaican guidelines are not specific as to a parity requirement. The guidelines state that clients should be screened for "parity, pregnancy outcomes and desire for more children" (p. 75). According to CTI, IPPF, and INTRAH guidelines, the IUD is best used by women who have had at least one child. The guidelines also link parity with the risk for STDs. Jamaican physicians are using this screening criterion; 58 percent of those interviewed in this study indicated that a client should have at least one child to be eligible for the method. The Jamaican guidelines do not recommend IUD use for women at risk of STDs. Farley et al., 1992, and WHO, 1984 state that these women can be offered the IUD, if they already have the children they want.

International guidelines do not specify a parity requirement for sterilization.

c. Other medical and social criteria

Counselling. Jamaican service delivery guidelines, like all other guidelines, stress the need for thorough counselling for clients regarding family planning in general and the contraceptive method chosen in particular. IPPF stresses the rights of the client to quality contraceptive care,

and the need for complete counselling on methods. The INTRAH guidelines make the following statement for all contraceptive methods: "Under most circumstances, a woman's risk of dying from pregnancy is many times greater than her risk of dying from using [method]. In fact, the higher a country's maternal mortality rate, the more important it is to offer a woman the safety of contraception" (p. 47). According to Matadial et al., 1985, writing in the West Indian Medical Journal, "In general, women with severe hypertension should be advised not to become pregnant, particularly if there was a previous history of superimposed pre-eclampsia." International guidelines note that clients should be screened for risk of PID/STDs and should be counselled accordingly about proper protection through contraception.

Contraindications for contraceptive use. The Jamaican guidelines list a number of the screening criteria mentioned by the private physicians, including for the pill: tobacco smoking (particularly over age 40), diabetes, liver condition, thromboembolic disorder, breast lump/cancer, irregular bleeding, cardiovascular problems (if over age 40), and breastfeeding. Screening criteria not listed in the guidelines for pill use include sickle cell disease, anaemia, respiratory problems, PID/STDs, weight, and migraine.

For use of the pill, IPPF and INTRAH stress the need to weigh the risks of childbearing against the risks of contraceptive use. For use of the pill, for example, INTRAH notes that if a woman is unwilling to use non-hormonal methods, she should be counseled on "the pill regardless of any of the following precautions (except pregnancy). Of course, any health problems should receive appropriate attention" (p. 47). INTRAH lists tobacco smoking, particularly for women over 40, as a contraindication. For diabetes, the guidelines note, "estrogens and progestins may slightly decrease glucose tolerance, but this is unlikely to happen with low dose COCs. Also, women with uncontrolled diabetes are at high risk for poor pregnancy outcome and need a very reliable method of contraception" (p. 50). INTRAH guidelines note that women with any two of the following conditions should be counselled to use a method other than the pill: over age 35, smoking, diabetes, and high blood pressure. For COCs, IPPF lists cerebrovascular or coronary artery disease and moderate to severe hypertension as contraindications to use, in addition to smoking over age 35, malignancy of the breast or genital tract and thromboembolic disorders.

For Depo-Provera, fewer conditions are mentioned in the Jamaican guidelines than for the pill. These conditions include breast lump/cancer, sickle cell disease, irregular bleeding, cardiovascular problems, and migraine. The guidelines list diabetes as a problem requiring medical assessment.

For Depo-Provera, diabetes is listed as another consideration in international guidelines; the guidelines, however, are equivocal about the use of Depo-Provera by women with diabetes. Suspicious breast lumps and pelvic/cervical cancer should also be assessed before providing Depo-Provera. Weight should be noted to establish a baseline in case the client gains weight with Depo-Provera use.

Screening criteria listed for the IUD include pelvic/cervical cancer, irregular bleeding, cardiovascular problems, PID/STDs, and multiple partners. For the IUD, international guidelines list pelvic/cervical cancer, irregular bleeding, aneamia, cardiovascular problems, PID/STDs, and

multiple partners as screening criteria (Hatcher et al., 1989, Huezo and Briggs, 1992, INTRAH, 1993). In addition, INTRAH lists uncontrolled diabetes as a screening criteria.

The Jamaican guidelines do not cover female and male sterilization, however a separate manual, which is currently being updated with assistance from the Access to Voluntary and Safe Contraception, International (AVSC), is available.

AVSC lists the following screening criteria for female sterilization: pelvic infection, heart disease, obesity, systemic or localized infection, pelvic or abdominal adhesions, respiratory problems, hypertension, diabetes, bleeding disorders, severe aneamia, and severe nutritional deficiencies. For female sterilization, INTRAH guidelines indicate that local VSC centers may screen for diabetes, anaemia, cardiovascular problems, and PID/STDs. Neither the Jamaican nor the international guidelines lists marriage as a prerequisite for sterilization or any other method.

d. Blood pressure criteria

Blood pressure levels listed as high in the Jamaican guidelines are systolic over 140-160 or diastolic over 90 on three or more readings. According to the INTRAH guidelines, high blood pressure is a systolic of 190 or above and a diastolic of 110 or above, or if the reading is over 160/90 on three occasions. IPPF simply lists hypertension as a contraindication to COCs, without defining blood pressure ranges. According to INTRAH, if a woman is under 35 and has never been told she had high blood pressure, "explain that a blood pressure check is desirable but not required before beginning hormonal contraceptives" (p. 50). Among the private physicians, the vast majority take blood pressure into consideration when screening for contraceptive use. Hypertension has been noted as a problem facing Caribbean populations, including Jamaica. The average blood pressure level listed by the physicians is slightly lower than that prescribed in the Jamaican and INTRAH guidelines.

e. Summary of eligibility criteria

It is interesting to note that not all of the private physicians screen for conditions deemed important by the Jamaican and international guidelines for pill use, including tobacco smoking over a certain age, liver condition, breast lump/cancer, irregular bleeding and cardiovascular problems. The same is noted for screening for other contraceptive methods. For example, irregular bleeding, aneamia, and PID/STDs are important for IUD use but were not mentioned by all Jamaican doctors in the survey. In addition, some private physicians screen for conditions inappropriate for the method. Depo-Provera for example is a method indicated for women with sickle cell disease, while 13 percent of the private physicians said they screened out women with sickle cell disease from using the injectable. According to Ceulaer et al. (1982), in a study conducted in Jamaica,

> Regardless of the mechanisms involved, the haematological changes on depo-provera treatment were in the direction that would be expected to be beneficial in patients with SS [sickle cell] disease. Experience in Jamaica over 18 years has

indicated depo-provera to be an effective contraceptive agent; the possibility that depo-provera may therefore be the contraceptive method of choice in patients with SS disease must be seriously entertained.

Although pregnancy is a contraindication for use of most methods of family planning (with the exception of condoms and spermicide, which also provide protection against STD/HIV transmission), none of the doctors mentioned it when listing screening criteria (although a few mentioned pregnancy test as a reason to postpone provision of a particular method.) It is likely that pregnancy is considered such a fundamental contraindication for use, that the doctors did not think it necessary to mention it.

2. How many clients do not meet the screening criteria for contraceptive use?

Although the information on clients not meeting eligibility criteria are estimates, they appear to be high. While the rates of such conditions as hypertension, diabetes and cervical cancer are higher in Jamaica than in many other countries, the risks to the health of clients using various methods of contraception should be carefully considered against the risk of unplanned pregnancy which may occur when using other less effective methods, or no method at all. According to INTRAH, "The major risk of giving hormonal contraceptives to a woman with unexplained bleeding is the risk of masking the signs of endometrial, ovarian or cervical cancer. However, 90 percent of endometrial cancers occur after the age of 50, and both endometrial and ovarian cancers are much less common in the developing world than in industrial countries. Therefore the chances of hormonal use masking endometrial or ovarian cancer are extremely small" (INTRAH, 1993).

3. Parental consent required for teenagers

According to the Jamaican guidelines, "the sexually active adolescent has a right to contraceptive services" (p. 35). No mention is made of parental consent for contraceptive use in either the Jamaican or the international guidelines.

4. Medical and laboratory tests required

Jamaican guidelines provide a chapter on physical assessment (including pelvic exam), pap smear and breast exam. With the exception of IUD use, the guidelines do not specify which of these exams should be conducted for the various contraceptive methods. For the IUD, a clinical history and pelvic exam are required. INTRAH guidelines refer providers to the physical, pelvic, breast and abdominal exams "if physical exams are performed at your service site" (p. 46). In addition to those exams, (which also include weight and blood pressure), no other exams or laboratory tests are listed as a prerequisite for any contraceptive method. IPPF lists history, physical exam and certain laboratory tests, but stresses that, for example, "COCs should not be withheld due to an absence of part or all of the physical or laboratory examinations if no contraindications are found to exist in the medical history" (Huezo and Briggs, 1992, p. 6). The Medical Barriers Guidelines Working Group stresses the need to ensure that clients not be sent

away without a contraceptive method; preferably the method they want. According to Grimes (1993), writing in the *Lancet*, certain screening services (e.g. serum cholesterol levels, blood pressure, breast and pelvic examinations) may be essential elements of preventive medicine in some settings, but they are not prerequisites for the safe use of hormonal methods.

While neither the Jamaican nor INTRAH guidelines mention the need for laboratory analysis of blood or urine, between seven and 41 percent of doctors require laboratory analysis of blood before provision of the various methods. Between 18 and 26 percent require laboratory analysis of urine before use of the various methods. The INTRAH guidelines note the importance of screening for PID and STDs (both through the history and visually).

C. Follow-up care

1. Follow-up schedules

According to the Jamaican guidelines, providers are to provide one cycle of pills during the first visit, three cycles during the second visit and to give six to 12 cycles thereafter. IPPF guidelines recommend clients be seen about three months after starting the pill and at least once a year thereafter. After the first (three month) visit, 10 or more cycles of pills can be given to the client. The INTRAH guidelines suggest giving two to three cycles during the first visit and at least three cycles thereafter. The Medical Barriers Guidelines Working Group stresses the need for a continuous supply of pills for clients. While clients should be encouraged to come back anytime for counselling, reassurance, or problems, there is no compelling medical reason for a routine follow-up visit before one year.

The Jamaican guidelines do not specify a return schedule for the IUD; according to the Medical Barriers Guidelines Working Group, clients should return one month after insertion. Thereafter, follow-up visits need not be fixed, however, clients should be encouraged to return if they have any of the following (or other questions or problems): late period, prolonged or excessive abnormal spotting or bleeding, abdominal pain, pain with intercourse, infection exposure, abdominal vaginal discharge or pelvic pain especially with fever, strings missing, or string seems shorter or longer. Visits are encouraged for other preventive reproductive health care.

2. Medical and laboratory tests required

The pelvic and pap smear exam and test conducted by the physicians is likely a reflection on the high incidence of infections and cervical cancer among Jamaican women. Neither the Jamaican nor international guidelines lists any exams or laboratory tests as required during follow-up visits, although various tests are recommended for the management of specific side effects.

3. Rest period from contraceptive use

The Jamaican guidelines do not suggest a rest period for any contraceptive method. To the contrary, the guidelines specifically address confusion about the pill, stating "there is not a justification for periodic withdrawal from the pill" (p. 45). The international guidelines do not state the need to take a rest period from any contraceptive method.

D. Factors influencing method provision

1. Reasons to postpone provision

According to the INTRAH guidelines, the pill can be initiated during the first seven days of menses or when the provider is sure that the client is not pregnant. The INTRAH guidelines also suggest that PID/STDs and dysfunctional bleeding be investigated and treated before certain methods, such as the IUD, are provided. In addition, combined oral contraceptives are not a good choice of method for breastfeeding women. The Jamaican guidelines do not address the issue of postponing the provision of methods.

2. Preference for and opposition to methods

Some of the reasons given by the private physicians for opposing various contraceptive methods are not based on current scientific and medical evidence. For example, the IUD is not an abortifacient (Croxatto, 1992), nor does NORPLANT® have a high failure rate (INTRAH, 1993). Depo-Provera does not cause infertility (Liskin, 1987), nor is it unsafe.

Chapter 7: Conclusions and Recommendations

"We need more refresher courses for General Practitioners."

"Training in family planning counselling needs to be emphasized."

"We are now conquering the old wives' tales concerning family planning and that is a great achievement."

Private Physicians, Jamaica

Conclusions

- Private physicians' practices are influenced by the socio-cultural and health environment within which they operate. Private providers, who supply 38 percent of family planning services in Jamaica (CPS, 1994), sincerely desire to provide high quality care and to ensure the safe use of contraceptives. The high incidence of hypertension and diabetes in Jamaica may be factors considered in restricting hormonal methods to some clients, using guidelines more cautiously than international recommendations. Physician practices are also affected by the likelihood that clients have multiple partners. Physicians' opinions of contraceptives are probably affected by the social view of menstruation and the value of fertility.

- There is a need to standardize the consistency of care given to clients. A client seeking services from different providers may be given a method by one provider and not by another. While it is clear that each individual client must be screened according to his or her own circumstances and conditions, more consistency of care may be warranted islandwide. The method a client uses is likely to be influenced by the provider's preferences among the methods. A client using a hormonal method or the IUD is likely to be encouraged to take a periodic rest from her method. Some clients whose provision of a method is postponed may be sent away with no other method and told to return to the service provider later. Men seeking sterilization have fewer requirements than women, including age, parity, marital status, other screening criteria, exams and laboratory analyses. Many private physicians will not provide teenage clients with contraception without the consent of parents.

- The health risks of clients using various methods of contraception should be carefully considered against the risk of unplanned pregnancy which may occur when using less effective methods or no method at all. Estimates of the percentage of clients not meeting eligibility criteria appear to be high.

- Choice of methods is restricted in some practices, due to:

  -- Provider preference. The method a client uses is likely to be influenced by the provider's preferences among methods.

  -- Procedures required by providers that are not necessary for the correct use of contraception (for example, frequent follow-up visits during contraceptive use, rest period requirements for some methods, and laboratory tests)

  -- Technical competence. Some physicians may not be providing optimum quality care to clients by not screening for important health conditions associated with various contraceptive methods (e.g. unexplained irregular bleeding, tobacco smoking and age, cardiovascular problems, PID/STDs).

Recommendations

Through research and experience, knowledge of contraceptive methods continually improves, as do the design and formulation of contraceptive methods. Reasons for service practices in Jamaica merit careful examination in light of current worldwide information on contraceptive methods. Many practices will be justified due to local Jamaican conditions for women and men using contraception, while others, once carefully evaluated, may be deemed unnecessary for the safe use of contraception.

- **Consistency of practice guidelines.** Service delivery guidelines can play an important role in standardizing the care that clients receive from service providers in any country. In 1991, the Ministry of Health and the National Family Planning Board developed national service delivery guidelines for family planning in the public sector. One-quarter of the private physicians know of the service delivery guidelines, a finding consistent with the fact that the guidelines were targeted to the public sector, but, due to funding constraints, were not widely disseminated. WHO will be updating medical criteria for selection of contraceptive methods in 1994, based in part on the work of a working group to update service delivery practices regarding hormonal methods and the IUD. When finalized, the recommendations from WHO should be put in the context of local medical and service delivery conditions in Jamaica.

  Through a participatory process of review by a wide range of service providers and relevant organizations (such as the NFPB, the MOH, the MAJ and the NAJ) in the country, Jamaica's *Family Planning Service Delivery Manual* could be updated to provide protocols on each contraceptive method, and then disseminated. By the admission of the private providers, there will be great demand for the manual among both private and public sector physicians who provide family planning in Jamaica.

- In addition, **training curricula** could be reviewed together with the service delivery guidelines to ensure consistency between the training providers receive and the guidelines they are given. Regular and refresher training could be conducted for private physicians to update them on contraceptive technology and the safe provision of family planning services. Revising the guidelines and providing training will help ensure that the care given to clients is more consistent across providers. Training in counselling for informed choice could help alleviate biases in the provision of contraception.

- A **legal and regulatory analysis** is being conducted in 1994, to review laws and regulations regarding contraceptives and family planning. Issues that have arisen in this study regarding parental and spousal consent, for example, are being addressed. The denial of contraceptive services to adolescents must be carefully examined against the health and socio-demographic implications of adolescent fertility.

- **Continuing education** for providers on contraceptive technology is important for improving both the ability and the quality of services. Subject areas for seminars must not only include clinical protocols for contraceptive use, but communication skills, counselling, and motivational techniques. A substantial proportion of the physicians who responded positively to the pilot project hope that participation will allow them access to educational materials and counselling aids for their clients (62 and 54 percent respectively.) They also are interested in projects that will upgrade their skills in contraceptive technology, clinical techniques and family planning counselling (59, 50, and 33 percent respectively).

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Appendix A

_________ Questionnaire No.

JAMAICA 6/93

Fertility Management Unit and
Institute for Social and Economic Research
The University of the West Indies
Mona, Kingston 7
Jamaica
Telephone: 92-72481

I. D. NUMBER

QUES.		NUMBER		PARISH	AREA

1993 PRIVATE PHYSICIAN'S SURVEY

Identification Information of Interview Location (Verify information)

Interviewee's Name: ____________

Address: ____________
____
____

Telephone: ____________

Fax: ____________

Parish: ____________

Health Region: 1 2 3 4

Area: 1-KMA 2-OMT 3-Rural

Specialty: (record from qs. 3a and 3b)
1-GP 2-OB/GYN 3-Surgeon
4-Other Specialist ____________

Interviewer Calls

Appointment	1	2	3
Scheduled: Date			
Time			
Date of Interview			
Time Started			
Time Ended			
Total Time			
Result*			

*Result Codes:

Completed	1
Not at Office	2
Unavailable/Rescheduled	3
Incomplete/Rescheduled	4
Incomplete/Terminated	5
Refused	6
Other (specify) ______	7

Control Information

Interviewer: ____________________

Approved:

Field Supervisor: ____________________ Date Reviewed: ____________ Yes No

Office Editor: ____________________ Date Reviewed: ____________ Yes No

Reason not approved: ________________________________

Coder: ____________________ Date: ____________

Data Enterer: ____________________ Date: ____________

Jamaica
Physician's Survey

Introduction

Good afternoon/evening. I am ______________ [full name]. I'm an interviewer from the University of the West Indies. As you are aware, we are conducting a study on behalf of UWI, MAJ, and the National Family Planning Board of private-practice physicians' involvement in family planning. We will speak with all private-practice physicians in Jamaica and would appreciate hearing your ideas. The results of this interview will be used to plan a pilot project with private physicians, including a map of all family planning service delivery locations islandwide.

The interview will take approximately 30 minutes. As a token of appreciation for your time we will provide you a copy of Contraceptive Technology at the completion of the interview. At the completion of the study we will send you a summary of the research results.

I. Individual's Background

1. Gender of physician (Do not ask. Interviewer record.)

   Male 1
   Female 2

2. How long have you been practicing medicine?

   __________ years

3a. Do you have any areas of specialty?

   Yes 1
   No 2 (skip to q. 4)

3b. What are your areas of specialty? (Circle all that apply)

   a. Family medicine 1
   b. Internal medicine 2
   c. OB/GYN 3
   d. Surgery 4
   e. Urology 5
   f. Public Health
   g. Other (specify) ________________ 6

4. During or after medical school, did you receive family planning training?

Yes 1
No 2 (If no, skip to q. 7)

5. Did this training include any of the following? (Read list. Circle all that apply)

Method	Training		
	Yes	No	DON'T KNOW
a. Family Planning Counseling	1	2	98
b. Condom Provision	1	2	98
c. Oral Contraceptives	1	2	98
d. IUD Insertion	1	2	98
e. Female Sterilization	1	2	98
f. Male Sterilization	1	2	98
g. Female Barrier Methods provision	1	2	98
h. Depo-Provera Injection	1	2	98
i. Norplant Insertion	1	2	98
j. Natural Family Planning	1	2	98
k. Other (specify) ____________	1	2	98

6. In your opinion, was this training adequate for you to provide these methods?

Yes 1
No 2
Don't know 98

II. Characteristics of Practice

Interviewer read: Now I would like to ask you some questions about your private practice.

*7. Does your private practice offer family planning methods?

Yes 1 (skip to q. 9)
No 2

8. What are your reasons for not providing family planning methods?

____
____
____

*9. Does your private practice offer family planning counseling?

Yes 1 (skip to q. 11)
No 2

10. Why do you not provide family planning information?

____
____
____

*11. Does your private practice refer clients for family planning services to another provider?

Yes 1 (Check qs. 7 and 9. If answers to both were no, skip to q. 59).
No 2 (Check qs. 7, 9 and 11. If answers to all three were no, skip to q.59).

12. In your private practice, at how many different locations do you provide family planning methods and/or counseling?

_________ locations

Now I would like to ask you a few questions about your private practice. Your addresses are needed for mapping purposes only and will not appear in the final study report.

Practice 1

13. What is the address and phone number of your first private practice? (Record below)

Address: ______________________________
____
____

Parish ______________________________

Phone: ______________________________

14. What days of the week and times of the day do <u>you</u> provide service in this private practice? (Record in chart below.)

Day of the week	Services offered		Hours (Specify a.m. and p.m.)
	Yes	No	
a. Monday	1	2	
b. Tuesday	1	2	
c. Wednesday	1	2	
d. Thursday	1	2	
e. Friday	1	2	
f. Saturday	1	2	
g. Sunday	1	2	
Interviewer comments:			

Practice 2

15. What is the address and phone number of your second private practice? (Record below.)

Address: ______________________________
____
____

Parish: ______________________________

Phone: ______________________________

16. What days of the week and times of the day do you provide service in this private practice? (Record in chart below.)

Day of the week	Services offered		Hours (Specify a.m. and p.m.)
	Yes	No	
a. Monday	1	2	
b. Tuesday	1	2	
c. Wednesday	1	2	
d. Thursday	1	2	
e. Friday	1	2	
f. Saturday	1	2	
g. Sunday	1	2	
Interviewer comments:			

Practice 3

17. What is the address and phone number of your third private practice? (Record below).

Address: ____________________

____

____

Parish: ____________________

Phone: ____________________

18. What days of the week and times of the day do you provide service in this private practice? (Record in chart below.)

Day of the week	Services offered		Hours (Specify a.m. and p.m.)
	Yes	No	
a. Monday	1	2	
b. Tuesday	1	2	
c. Wednesday	1	2	
d. Thursday	1	2	
e. Friday	1	2	
f. Saturday	1	2	
g. Sunday	1	2	
Interviewer comments:			

*19 & 20. What types of family planning services are offered at each of your private practices? Which methods do you refer for? (Prompt for practices listed in questions 13, 15 and 17. Show categories and circle all that apply. Record methods referred for in Q. 20.)

Service	19a Practice 1	19b Practice 2	19c Practice 3	20 Refer for	21 Reason
a. FP Counseling	1	1	1	1	
b. Prescriptions and provision of oral contraceptives	2	2	2	2	
c. Depo-Provera	3	3	3	3	
d. IUD	4	4	4	4	
e. Female Sterilization	5	5	5	5	
f. Male Sterilization	6	6	6	6	
g. Norplant	7	7	7	7	
h. Condom	8	8	8	8	
i. Female Barrier Methods	9	9	9	9	
j. Natural Family Planning	10	10	10	10	
k. Other (specify)	11	11	11	11	

21. What is the primary reason you don't offer ______________? (Prompt for each method not offered in any private practice. See reason code list below but do not prompt for reasons. Record first reason mentioned in Q21 in chart above.)

Reason codes

Counseling takes too long	1
Too time consuming/cannot make adequate compensation	2
Not trained/qualified in required procedures	3
Do not have required equipment	4
Do not have necessary supplies	5
Limited demand	6
Have concerns about safety of method	7
Prohibited by law	8
Other (specify) ______________________	9

22. In your private practice [with the most family planning clients], which of these staff provide family planning counseling? (Read categories, record in chart below.)

Designation	FP Counseling	
	Yes	No
a. Doctors	1	2
b. Nurse	1	2
c. Receptionist	1	2
d. Other (Specify) ________	1	2

23. Which staff in your private practice administer the following methods? (Read methods provided by physician, from q. 19. For each method circle all providers that apply)

Method/Provider	Doctor	Nurse	Other (specify)
a. Pill	1	2	3 ________
b. Depo-Provera	1	2	3 ________
c. IUD	1	2	3 ________
d. Female steril.	1	2	3 ________
e. Male steril.	1	2	3 ________
f. Norplant	1	2	3 ________

24. On average, how many clients do you see a week (total clients, not only family planning)?

a. ____________ clients
b. Don't know 98

25. On average, how many of these clients are family planning clients?

a. ____________ clients
b. Don't know 98

26. Approximately how much time do you spend counseling each <u>new</u> family planning acceptor?

________ minutes

III. Service Delivery Practices

Now I would like to ask you some questions about your provision of family planning methods.

Interviewer: check q. 19. Does physician provide, prescribe or refer for pills? If no, skip to q. 29.)

27. **When considering a client for the pill what are your eligibility criteria for use (Prompt only for starred (*) items.)**

Restrictions	Nature of eligibility criteria	
*a. Minimum age		
*b. Maximum age		
*c. Blood pressure (state maximum acceptable)	Systolic:	Diastolic:
*d. Tobacco smoker	1 Yes	2 No
*e. Tobacco smoker over a certain age	1 Yes	2 No
f. Diabetes (of client or in family)	1 Yes	2 No
g. Liver condition (jaundiced eyes)	1 Yes	2 No
h. Varicose veins	1 Yes	2 No
i. Breast lump/cancer	1 Yes	2 No
j. Irregular bleeding	1 Yes	2 No
k. Anemia	1 Yes	2 No
l. Cardiovascular problems	1 Yes	2 No
m. Respiratory problems	1 Yes	2 No
n. Sickle cell disease	1 Yes	2 No
o. PID/STD	1 Yes	2 No
p. Breastfeeding	1 Yes	2 No
q. Other __________		
r. Other __________		

28. **Of the clients you screen for pill use what, in your estimate, is the percent who do not meet your eligibility criteria above.**

________ %

Interviewer: check q. 19. Does physician provide or refer for Depo-Provera?
If no, skip to q. 31.)

29. When considering a client for Depo-Provera what are your eligibility criteria for use (Prompt only for starred (*) items.)

Restrictions	Nature of eligibility criteria	
*a. Minimum age		
*b. Maximum age		
*c. At least ________ children		
*d. Blood pressure (state maximum acceptable)	Systolic:	Diastolic:
*e. Tobacco smoker	1 Yes	2 No
*f. Tobacco smoker over a certain age	1 Yes	2 No
g. Diabetes (of client or in family)	1 Yes	2 No
h. Liver condition (jaundiced eyes)	1 Yes	2 No
i. Varicose veins	1 Yes	2 No
j. Breast lump/cancer	1 Yes	2 No
k. Irregular bleeding	1 Yes	2 No
l. Anemia	1 Yes	2 No
m. Cardiovascular problems	1 Yes	2 No
n. Respiratory problems	1 Yes	2 No
o. Sickle cell disease	1 Yes	2 No
p. PID/STD	1 Yes	2 No
q. Breastfeeding	1 Yes	2 No
r. Other ________		
s. Other ________		

30. Of the clients your screen for Depo-Provera use, what, in your estimate, is the percent who do not meet your eligibility criteria above?

________ %

Interviewer: check q. 19. Does physician provide or refer for the IUD? If no, skip to q. 33.)

31. When considering a client for the IUD what are your eligibility criteria for use (Prompt only for starred (*) items.)

Restrictions	Nature of eligibility criteria	
*a. Minimum age		
*b. Maximum age		
*c. At least ______________ children		
*d. Multiple partners	1 Yes	2 No
e. Pelvic cancer	1 Yes	2 No
f. Irregular bleeding	1 Yes	2 No
g. Anemia	1 Yes	2 No
h. Cardiovascular problems	1 Yes	2 No
i. Respiratory problems	1 Yes	2 No
*j. PID/STD	1 Yes	2 No
k. Breastfeeding	1 Yes	2 No
l. Other ___________		
m. Other ___________		

32. Of the clients you screen for IUD use what, in your estimate, is the percent who do not meet your eligibility criteria above.

________ %

Interviewer: check q. 19. Does physician provide or refer for female sterilization? If no, skip to q. 35.)

33. When considering a client for female sterilization what are your eligibility criteria for use (Prompt only for starred (*) items.)

Restrictions	Nature of eligibility criteria	
*a. Minimum age		
*b. Maximum age		
*c. At least ____________ children		
d. Weight		
e. Blood pressure (state maximum acceptable)	Systolic:	Diastolic:
*f. Marital status	1 Yes	2 No
g. Diabetes (of client or in family)	1 Yes	2 No
h. Liver condition (jaundiced eyes)	1 Yes	2 No
i. Varicose veins	1 Yes	2 No
j. Breast lump/cancer	1 Yes	2 No
k. Irregular bleeding	1 Yes	2 No
l. Anemia	1 Yes	2 No
m. Cardiovascular problems	1 Yes	2 No
n. Respiratory problems	1 Yes	2 No
o. Sickle cell disease	1 Yes	2 No
p. PID/STD	1 Yes	2 No
q. Breastfeeding	1 Yes	2 No
r. Other ____________		
s. Other ____________		

34. Of the clients you screen for female sterilization what, in your estimate, is the percent who do not meet your eligibility criteria above?

____________ %

Interviewer: check q. 19. Does physician provide or refer for male sterilization? If no, skip to q. 37.)

35. When considering a client for male sterilization what are your eligibility criteria for use (Prompt only for starred (*) items.)

Restrictions	Nature of eligibility criteria	
*a. Minimum age		
*b. Maximum age		
*c. At least ____________ children		
d. Weight		
e. Blood pressure (state maximum acceptable)	Systolic:	Diastolic:
*f. Marital status	1 Yes	2 No
g. Diabetes (of client or in family)	1 Yes	2 No
h. Liver condition (jaundiced eyes)	1 Yes	2 No
i. Varicose veins	1 Yes	2 No
j. Anemia	1 Yes	2 No
k. Cardiovascular problems	1 Yes	2 No
l. Respiratory problems	1 Yes	2 No
m. Sickle cell disease	1 Yes	2 No
n. STD	1 Yes	2 No
o. Other __________		
p. Other __________		

36. Of the clients you screen for male sterilization, what in your estimate, is the percent who do not meet your eligibility criteria above?

________ %

37. Are there any methods that you recommend clients to rest, or take a break from using?

Yes 1
No 2 (skip to q. 40)

38 & 39. Which methods do you recommend a rest from, and why?

Method	38. Recommend a rest		39. Reason
	Yes	No	
a. Pill	1	2	
b. Depo-Provera	1	2	
c. IUD	1	2	
d. Other______	1	2	

40. Are you aware of a Jamaican manual which contains guidelines for family planning service delivery?

Yes, one exists 1
No, one does not exists 2 (skip to q. 43)
Don't know 98 (skip to q. 43)

41. Does this private practice use the manual?

Yes 1 (skip to q. 43)
No 2

42. If no, why not (circle all that apply)

a. Don't have a copy 1
b. Outdated information 2
c. Already know the information 3
d. Other (specify) ________________________ 4

43. Do you require the consent of parents so that sexually active teenagers under 16 can receive a contraceptive method?

Yes 1
No 2 (If no, skip to q.46)

44. For the methods that you provide, for which do you require parental consent? (Unprompted.)

Method	Consent	
	Yes	No
a. Pill	1	2
b. Depo-Provera	1	2
c. Condom	1	2
d. Female barrier methods	1	2
e. IUD	1	2

45. What do you do if the teenager under 16 does not have parental consent? (Unprompted. Circle all that apply.)

a. Do not provide any method 1
b. Refer to another family planning provider 2
c. Suggest another method 3
d. Convince the parents to give permission 4
e. Provide the method anyway 5
f. Other (specify) ____________ 6

IV. Medical/Lab Exams

Check question 19 for methods provided.

46. **Which exams and laboratory analyses do you routinely require before providing the following contraceptive methods? (Read methods provided, from q. 19. Circle all tests/exams that apply. Do not prompt for tests.)**

Exam/Analysis	(a) Pill	(b) Female Barrier	(c) Depo-Provera	(d) IUD	(e) Female Sterilization	(f) Male Sterilization
a. None required	1	1	1	1	1	1
b. Clinical history	2	2	2	2	2	2
c. Complete physical exam	3	3	3	3	3	3
d. Weight	4	4	4	4	4	4
e. Pelvic exam	5	5	5	5	5	5
f. Blood pressure	6	6	6	6	6	6
g. Laboratory analysis of blood	7	7	7	7	7	7
h. Laboratory analysis of urine	8	8	8	8	8	8
i. Laboratory analysis of STDs	9	9	9	9	9	9
j. Pap Smear	10	10	10	10	10	10
k. Other (specify)__________	11	11	11	11	11	11

47. **If no problems arise, how many follow-ups visits are regularly scheduled for:**

Oral Contraceptives: a. First year ________

b. Subsequent years ________

IUDs: c. First year ________

d. Subsequent years ________

48. Which exams and laboratory analyses are routinely required for follow-up visits for the following methods? (Read methods provided, from q. 19. Circle all tests/exams that apply. Do not prompt for tests.)

Exam/Analysis	a Pill	b Female Barrier	c Depo-Provera	d IUD
a. None required	1	1	1	. 1
b. Physical exam	2	2	2	2
c. Weight	3	3	3	3
d. Pelvic exam	4	4	4	4
e. Blood pressure	5	5	5	5
f. Pap Smear	6	6	6	6
g. Other (specify)_______________	7	7	7	7

49. Where does the client go for blood and other laboratory analyses?

a. Done on location 1
b. Within greater facility 2
c. Elsewhere 3
d. Estimated distance from your private practice_______________ (in miles)
e. None required 5

V. Factors Affecting Method Provision

50. Are there any methods that you postpone the initial provision of for the following reasons? (Read reasons below and circle all that apply for each method mentioned.)

Reason	a Pill	b Depo-Provera	c IUD	d Female Sterilization	e Male Sterilization
a. No reason to postpone method (skip to q. 52)	1	1	1	1	1
b. Menstruation	2	2	2	2	NA
c. Breastfeeding <6 weeks	3	3	3	NA	NA
d. Breastfeeding 6 weeks or longer	4	4	4	NA	NA
e. Lack of Supplies/ Equipment	5	5	5	5	5
f. Parental Consent	6	6	6	6	6
g. Other (specify)________ ________ ________	7	7	7	7	7

51. What do you do if you postpone the provision of a method? (Circle all that apply.)

a. Provide another method 1
b. Refer to another provider 2
c. Tell client to return later 3
d. Other (specify) ____________________ 4

52. Do you tend to prefer any method in particular for the following types of clients? Why do you prefer that method? (For (c) see responses below and list all that apply.)

a. Type of client	b. Preference of method	c. Reason (see below)
a. For women who want to delay their first birth (delay)		
b. For women who want to space their next birth (space)		
c. For women who want to stop having children (limit)		

Answer categories for (c)

Least side effects	1
Safe	2
Most effective	3
Not too expensive for users	4
Most acceptable	5
Most professional experience with method	6
Easy to use	7
Little discontinuation of method	8
Other (specify ______________)	9

53. Are there any contraceptive methods that you are opposed to?

Yes 1
No 2 (skip to q. 56)

54 & 55. If yes, what methods and why? (Unprompted.)

Method	54. Oppose		55. Reason
	Yes	No	
a. Pill	1	2	
b. Depo-Provera	1	2	
c. Condom	1	2	
d. Female Barrier Methods	1	2	
e. IUD	1	2	
f. Female sterilization	1	2	
g. Male sterilization	1	2	
h. Natural Family Planning	1	2	
i. Abortion	1	2	
j. Morning After Pill	1	2	
k. Norplant	1	2	

56. What fee do you charge for a family planning office visit for a new acceptor? (Read categories.)

a. Less than J$200 1
b. J$200-300 2
c. J$301-400 3
d. More than J$400 4
e. No response 99 (Skip to q. 58)

57. What fees do you charge for the initial provision of the following methods (Ask only for methods provided by the physician, from q. 19.)

Contraceptive Method	Fee (J$)	No response
a. Pill (prescription or provision)		99
b. Depo-Provera (injection)		99
c. IUD (insertion)		99
d. Female sterilization		99
e. Male sterilization		99
f. Condom (provision)		99
g. Female Barrier Methods (provision)		99
h. Other ______________ ______________		

58. Which factors do you feel hinder your ability to expand provision of family planning? (Show response card. Circle all that apply.)

a. No consistent guidelines	1
b. No training in providing/prescribing contraceptives	2
c. No information on new advances in contraception	3
d. Cost of contraceptives to provider	4
e. No money to be made in family planning	5
f. Unwillingness of clients to pay a reasonable price	6
for family planning services	7
g. Cost of equipment	8
h. Poor contraceptive supply	9
i. Lack of time	10
i. Attitudes of medical personnel	11
j. Beliefs and traditions of the population	12
k. Other ____________________	13
l. Don't know	98

59. In your opinion, what could be done to motivate private-practice physicians to become more involved in family planning? (Unprompted. Circle all that apply.)

a. Greater financial compensation	1
b. Financial incentives	2
c. Free start-up samples	3
d. Training in family planning counseling	4
e. Training in family planning methods	5
f. Educational materials for clients	6
g. Educational materials for providers	7
h. Resensitizing to family planning concerns	8
i. Other (specify)____________	9
j. Don't know	98

VI. Pilot Project

60. In a few months, the National Family Planning Board will design a pilot project to involve more private physicians in family planning. Please tell me whether you would be interested in participating in or receiving any of the following: (Show responses. Circle all that apply.)

a. Refresher course in contraceptive technology	1	skip to q. 62
b. Training in family planning counseling	2	
c. Clinical training (specify method ______)	3	
d. Educational materials for clients	4	
e. Counseling aids	5	
f. Other (specify)______	6	
g. Not interested in any	7	

61. Why aren't you interested in any of these activities (Circle all that apply.)

a. Can't make money in family planning	1	skip to q. 63
b. Not interested in fp/specializes in another area	2	
c. Too busy to expand practice	3	
d. Too many follow-up problems arise with fp	4	
e. Other (specify) ______	5	

62. If you became involved in expanded family planning service delivery, what would your needs be? (Unprompted. Circle all that apply.)

a. Additional administrative staff	1
b. Additional counseling staff	2
c. More space	3
d. Supplies (specify______)	4
e. Equipment (specify______)	5
f. Mini-surgery facilities	6
f. Training for staff	7
d. Educational materials for clients	8
e. Other (specify) ______ ______	9

63. Do you have anything that you would like to add to what we have discussed?

____

____

____

____

____

Thank you for taking the time to answer these questions. Your responses will be very helpful for the National Family Planning Board to increase access to family planning services in Jamaica. Please accept this copy of Contraceptive Technology as thanks for participating in this survey.

Interviewer's comments:

____

____

____

End Interview Note Time: __________

Appendix B. Research Team

National Family Planning Board

Mrs. Beryl Chevannes, Executive Director
Dr. Olivia McDonald, Medical Director
Mrs. Marian Kenneally, Futures Group Adviser

The University of the West Indies

Institute for Social and Economic Research

Dr. Wilma Bailey, Principal Investigator
Dr. Vincent George, Consultant

Data entry students:
Mohan Baro
Cecil Bernard
Allison Dundas
Dennis Grant
Andrea Miller
Heather Ricketts
Thalein Williams

Fertility Management Unit

Dr. Hugh Wynter, Director
Mrs. Jean Jackson, Researcher
Mrs. Jean Monroe, Field Supervisor
Ms. Amy Lee, Field Supervisor
Ms. Patricia Oliver, Field Supervisor

Field Staff:

Ann-Marie Chandler	Graduate student
Winsome Cole	Guidance counsellor
Casonova Creary	Research assistant
Maureen Dwyer	Graduate student
Alwyn Fearon	Nurse
Aldrie Henry	Graduate student
Marcia Henry	Nurse
Carol Hines	Nurse
Joyclyn McGhie	Midwife
Marcia McKay	Nursing sister

Audrey Morris	Graduate student
Cora Ramsay	Health educator
Lettie Russell	Nurse
Desrene Walters	Nursing sister

Department of Geography

Dr. Anne Lyew-Ayee

The Medical Association of Jamaica

Dr. Margaret O. Green, President

The Futures Group

Ms. Maureen Clyde, Senior Research Scientist
Ms. Susan Smith, Research Associate

Family Health International

Dr. Karen Hardee, Senior Research Associate
Ms. Michele T. Villinski, Senior Research Analyst

Appendix C

ADVANCED TRAINING & RESEARCH IN FERTILITY MANAGEMENT

Department of Obstetrics and Gynaecology

DEPT. of OB & GYN.
U.W.I.

The University of the West Indies
P.O. Box 48, Mona
Kingston 7, Jamaica
Telephone: 92-71620-9 Ext. 2304-5
Fax: 92-77382

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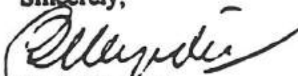
Dear Dr.

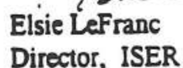
The National Family Planning Board is considering opportunities to expand the delivery of family planning services and to increase the participation of the private sector in service delivery. This requires an understanding of the availability of existing services both in the private and public sectors. The Fertility Management Unit and the Institute of Social and Economic Research of the UWI have been contracted to identify and map all family planning service delivery points (SDPs), the types of services offered including counselling and their hours of operation. In addition, the Board needs information on private practitioners' interest and skill in the provision of long term and permanent contraceptive methods.

Doctors would have to be approached directly to obtain the necessary information. You should, by this time, have received a letter from The National Family Planning Board asking for your co-operation in the field exercise. We hope to complete it within the space of five weeks and can only do so with that co-operation. Our field officers will be getting in touch with you to make arrangements for an interview at your earliest convenience. We look forward to your assistance in this important enterprise.

Sincerely,



Hugh Wynter
Director, FMU



Elsie LeFranc
Director, ISER

Appendix D

NATIONAL FAMILY PLANNING BOARD

THE JUNE RATTRAY BUILDING
5 SYLVAN AVENUE,
P.O. BOX 287,
KINGSTON 5, JAMAICA, W.I.

21st June, 1993

Ref. No............

Dr..........................

....

....

Dear Doctor:

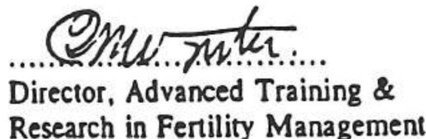
The National Family Planning Board, in collaboration with the Medical Association of Jamaica, UWI, Advanced Training and Research in Fertility Management/Institute for Social and Economic Research, and the US Agency for International Development, is conducting a study to assess the current availability of family planning services island wide. The results of the study will be used by its sponsors to develop a pilot project with interested private physicians to provide new or expanded family planning services. This is in support of the national population policy goal to increase contraceptive prevalence from the current estimated 55% of women of reproductive age to approximately 63% by the year 2000 and to strive for family planning programme sustainability in view of imminent dwindling of Government of Jamaica and foreign donor funding.

The University of the West Indies, Advanced Training and Research/Institute for Social and Economic Research (UWI/FMU/ISER) has been contracted to conduct the study, which will take place from now until September 1993. An interviewer from UWI/FMU/ISER will be contacting you soon to schedule an appointment during the month of July 1993 to conduct a face-to-face interview, which will last approximately 30 minutes. In appreciation for your valuable time given in the completion of the questionnaire and your participation in the survey we will be providing you with a copy of the international edition of the book Contraceptive Technology. Also, when the study is completed, the National Family Planning Board will mail you a report on the research results.

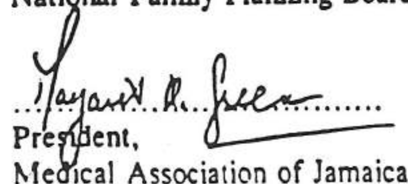
Your participation is crucial to ensure the development of a private physicians' pilot project that is effective, cost-efficient, and acceptable to the medical community in Jamaica. We look forward to your cooperation and our working together on this joint venture. If you have any questions or suggestions, please contact Dr. Wilma Bailey, Principal Investigator for UWI/FMU/ISER at 927-1020........

Sincerely,

Executive Director,
National Family Planning Board



Director, Advanced Training &
Research in Fertility Management



President,
Medical Association of Jamaica