A Situation Analysis of Family Planning in Ethiopia – June 2011

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LIST OF ABBREVIATIONS AND ACRONYMS

COC	Combined oral contraceptive pill
CPR	Contraceptive prevalence rate
DHS	Demographic and Health Survey
EPHA	Ethiopian Public Health Association
FHI 360	Formerly: Family Health International
FP	Family planning
FMOH	Federal Ministry of Health
GoE	Government of Ethiopia
HEP	Health Extension Program
HEW	Health Extension Worker
HMIS	Health Management Information System
HP	Health Post
IEC	Information, education and communication
IFHP	Integrated Family Health Program
IUCD	Intrauterine contraceptive device
KAP	Knowledge, attitudes and practice
LAPM	Long-acting or permanent method
OCP	Oral contraceptive pill
MCH	Maternal and child health
MDG	Millennium Development Goals
POP	Progestin-only pill
RTI	Reproductive tract infection
STI	Sexually transmitted infection
SNNP	Southern Nations Nationalities and Peoples
TFR	Total fertility rate

EXECUTIVE SUMMARY

Background

To respond to the low utilization of preventative health services in Ethiopia, the Federal Ministry of Health (FMOH) launched the Health Extension Program (HEP) in 2003 with a strong emphasis placed on rural health care services. In a novel approach to task sharing, this program included the development of the rural health extension worker (HEW) as a new cadre of government-employed health worker. The HEWs provided an opportunity to expand family planning (FP) services to rural areas in Ethiopia. Thus in 2009, the FMOH launched a program to train HEWs to insert Implanon, a single rod contraceptive implant, at health posts (HP) as a means to expand the method mix that had previously been composed largely of short acting methods. With the expansion of the Implanon initiative, in 2010, the FMOH also launched a revitalization program for the intrauterine contraceptive device (IUCD), initially in 116 woredas from six regions of Ethiopia. The expansion of the method mix to include long-acting methods will inevitably support the Government of Ethiopia (GoE) to meet Millennium Development Goals (MDG). The government has set the goal to achieve a total fertility rate (TFR) of 4 and a contraceptive prevalence rate (CPR) of 65% by 2015.

This study was designed to assess the readiness of the health system to expand FP service delivery in the selected sites, particularly long acting and permanent methods (LAPMs).

Methods

This cross-sectional study was designed and implemented using the Situation Analysis methodology, collecting data using provider interviews, facility inventories, service delivery observation, and exit interviews with FP clients. Up to one hospital, two health centers, and two health posts per woreda were selected into the study. Data were collected by a field team that included nurses, health officers, and public health professionals.

Summary of the findings

Sample characteristics

Results show that almost all FP service providers at the hospitals and health centers (98%) were nurses or health officers, while at the health posts, 98% were trained as HEWs. The FP providers were mostly female, with an average age of 28.3 in hospitals and health centers, and 23.2 at the health posts.

FP clients were mostly married and of the Ethiopian Orthodox religion, and the majority, especially in health posts, had no formal education.

Personnel, infrastructure, equipment, and operations

In hospitals and health centers, nearly half of the providers had received training in IUCD insertion, and 52% had received training in IUCD removal. Additionally, nearly 60% had received training in implant insertion and removal. In comparison, 37% of the HEWs had received training in Implanon insertion—the only implant authorized for insertion at health post level—and 3% had received training in Implanon removal. No HEWs are being trained in IUCD insertion or removal.

Results on the basic infrastructure for FP services show that running water at the FP/MCH unit was available in 72% of the hospitals, 40% of the health centers and only 8% of the health posts[1]; and washing bowls were available in the FP/MCH units of 72% of the hospitals, 49% of the health centers and 22% of the health posts. However, the overall FP service delivery environment was good in all facility types. Most hospitals and health centers had the necessary equipment for delivering long acting FP methods.

Compared with the hospitals and health centers providers (33%), a large percent of the HEWs had the perception that their workload was too high (62%), although this this perception should be interpreted with caution given that this study was not necessarily designed to adequately investigate workload—a more appropriate investigation on workload requires an in-depth assessment, encompassing observation of HEWs delivering services over a period of time. Such a detailed analysis of workload as this was not the main purpose of the study, which renders the interpretation of this finding limited. Results also showed that FP services were provided five days in a week in most health facilities, and the majority of FP clients considered facility operating hours to be convenient.

Reasons for client visit and availability of FP services

The main reason for visiting the health facility for most of the FP clients was to obtain a re-supply of their FP method. New FP users constituted just over one fifth (22%) of the hospitals and health centers clients, and in health posts, 11% of the clients were new FP users. Generally, most health facilities reported usually providing a range of short acting methods, with injectables being the most available and the most dispensed method. Hospitals and health centers had on average, over four different FP methods available at the time of the survey. Of the long acting methods, Implanon was relatively more available than the other long acting methods.

[1] Note that in health posts, there is no separate unit for FP/MCH as all services are provided within the same service delivery point

Supplies and logistics managements

Most of the facilities that reported usually providing a particular FP method were found to also have it in stock at the time of the survey, but these facilities also had experienced stock-outs in the past six months. In the facilities that usually provided IUCDs, 93% also had it in stock at the time of the survey. Of the facilities that usually provided Implanon, it was generally found to be in stock at the time of the survey. Overall, more than 90% of all facilities had injectables and OCPs in stock.

Facility observations showed that most of the hospitals and health centers had better ordered record card systems than the health posts (82% compared to 57%). Written inventories for FP methods were however lacking in a number of health facilities.

Quality of care

Most of the FP clients reported receiving services at no cost. For hospital and health center clients the common tendency of the providers (52%) was to dispense 3-4 cycles of pills at each client visit for clients who had been on OCPs for at least one year. Comparatively, the majority of the HEWs tended to dispense 1-2 cycles at each visit.

Most of the providers who had conducted IUCD and implant insertions reported that they were comfortable with conducting insertions, but for those who had not conducted any insertions, the lack of training was cited as the primary reason. However, the majority of providers (including those who had never been trained in IUCD and implant services) were interested in providing IUCDs and implants.

Generally, most of the providers interviewed had specific influencing factors for dispensing FP methods. These factors included: minimum and maximum age, marital status, partner consent, and menstrual status. Among nurses and health officers, for example, the stated mean minimum age for prescribing OCPs was 15.4 years compared with 15.9 among HEWs, with a maximum of 44.2 and 42.8 respectively. For implants, however, there was a major difference between the ages recommended by nurses and health officers versus HEWs (minimum of mean age of 16.6 among nurses and health officers, but 18.6 among HEWs). With the exception of sterilization, the majority of providers were open to dispensing FP methods to non-married clients, the main difference being that while 76% of the nurses and health officers were open to inserting implants to unmarried women, only about half of the HEWs would.

Based on observations of service delivery, we found that in 71% of the observations, hospital and health center providers obtained the biographical information of the clients. This was higher than in health posts where client's biographical information was collected only from 44% of the clients.

Similarly, in observations conducted in hospitals and health centers, clients were more likely to be asked what their reproductive goal was compared with observations conducted in health posts providers. During counseling, in 95% of the observations of service delivery to new or restarting FP clients at hospitals and health centers, and in 83% of the observations at health posts, clients were asked by the providers what their method of preference was. The majority of the clients, both in hospitals and health centers, and in health posts indicated a method of preference.

Conclusion

Based on these findings, most of the health facilities surveyed appear to have the capacity for provision of short acting methods, and while the basic infrastructure for IUCD and implant insertion exists, training both existing and new providers is necessary to expand coverage. Provider interest to conduct IUCD and implants services is also evident. While it is not the plan of the FMOH to allow IUCD insertion by HEWs, the HEWs interviewed in this study expressed interest in receiving training on IUCD insertion. The findings also show that for the sites studied, the government strategies to improve access to FP services have been successful given the observation of the exit clients that facilities are within walking distance, and operating hours are convenient. One of the main infrastructural areas for improvement is increasing availability of water in the FP/MCH units, particularly in health posts.

This study has also established that possible barriers to long acting methods uptake mostly include low awareness, particularly of IUCDs, and provider perceptions of restrictions related to client's age parity, marital status, menstruation, and husband consent. Additionally, current FP guidelines do not discuss any of these possible limitations and how they can be addressed, which calls for consideration for reviewing or supplementing the existing guidelines to address these issues. Furthermore, HEWs perceive their workload to be heavy. Because this study was not designed to sufficiently measure workload adequately, further investigation may be necessary to determine whether the HEWs really have a heavy workload and what exactly may be causing the perceived heavy work burden on HEWs. The general observation based on the recommended HEWs activities is that their full potential has not yet been fully exploited.

STUDY BACKGROUND AND RATIONALE

In response to the low utilization of preventative health services in Ethiopia, the Federal Ministry of Health (FMOH) launched the Health Extension Program (HEP) in 2003. This program "focuses mainly on providing quality promotional, preventive, and selected curative health care services in an accessible and equitable manner to reach all segments of the population, with special attention to mothers and children."[2] A strong emphasis is placed on rural health care services.[3] In a novel approach to task sharing, the new program included the development of the rural health extension worker (HEW) as a new cadre of government employed health worker. Rural HEWs complete a one-year training course and are trained to provide a package of primary health care services including the provision of family planning (FP) services.

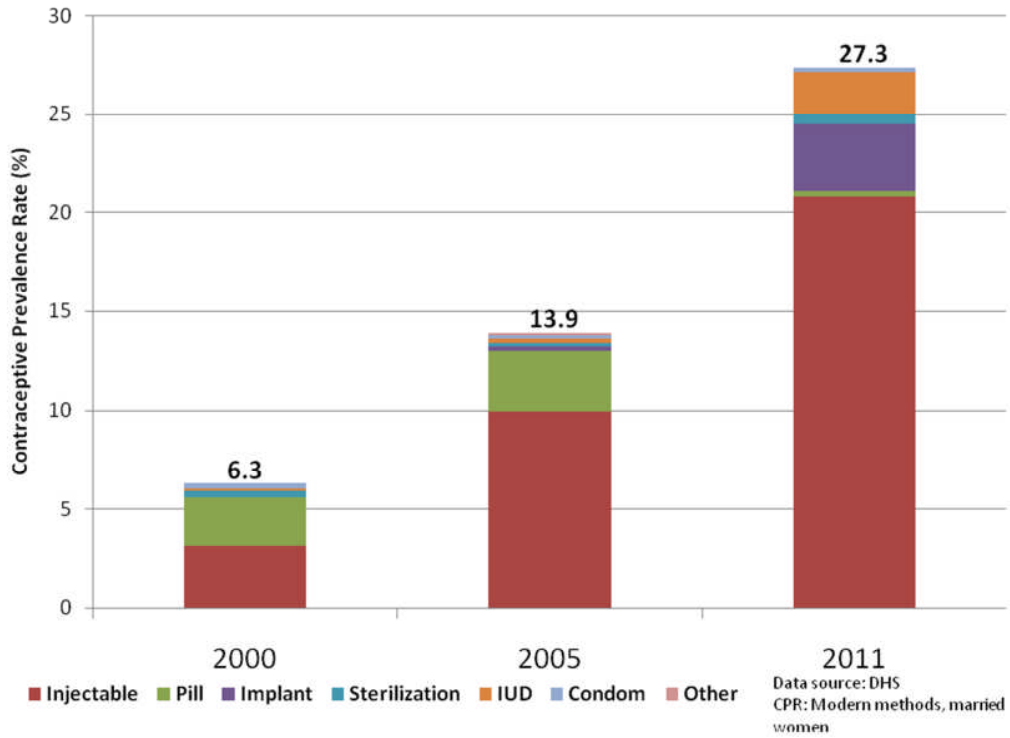
In 2009, the FMOH in collaboration with implementing partners began training HEWs to insert Implanon at health posts (HP), which expanded the FP options available at the kebele-level[4] to include Implanon[5], condoms, pills, and injectables. The FMOH intends to train at least one HEW per health post to insert Implanon for a total of 15,000 Implanon-trained HEWs. Beginning in 2010, the FMOH began planning a further expansion of the FP method options through a revitalization of the intrauterine contraceptive device (IUCD). Training and expansion of IUCD services is currently underway in 116 selected woredas[6].

The Government of Ethiopia (GoE) is committed to meeting the Millennium Development Goals (MDGs) and has set country-level population goals of a total fertility rate (TFR) of 4 and a contraceptive prevalence rate (CPR) of 65% by 2015.[7] While the commitment remains strong, the challenge of meeting the MDGs is a reality as Ethiopia has an estimated total population of 77,079,609[8]. The population growth rate in Ethiopia has however declined from 3.1% per annum in 1984 to 2.6% in 2007[9]. Nearly half (46.2%) of the population is under 15-years-old and notably, 20,100,000 women are within reproductive age (15-49 years). The number of women of

[2] http://www.moh.gov.et/English/Resources/Documents/HEW%20profile%20Final%2008%2007.pdf
[3] Health Extension Program in Ethiopia: Profile. Health Extension and Education Center, Federal Ministry of Health, Addis Ababa, Ethiopia.
[4] A kebele is the smallest administrative unit in Ethiopia, similar to a ward or neighborhood.
[5] HEWs are only trained to insert Implanon and are not trained to insert other contraceptive implants. In this report, the type of implant is differentiated to highlight this distinction in service provision.
[6] A woreda is the second smallest administrative unit in Ethiopia, similar to a district.
[7] Federal Democratic Republic of Ethiopia Ministry of Health. Health Sector Development Program IV 2010/11 – 2014/15. 2010. Addis Ababa, Ethiopia.
[8] Central Statistics Agency of Ethiopia. (2011) Welfare Monitoring Survey—Statistical report. Addis Ababa
[9] Ethiopia Demographic Health Survey. (2011). Central Statistical Agency, Addis Ababa, Ethiopia and ICF International Calverton, Maryland, USA

reproductive age will increase considerably as the women under 15 years (currently 20,400,000 women) age into reproductive age. Additionally, the logistical challenge of supplying these women with FP poses a challenge as 83% of the population lives in rural areas.[10] Fertility is still high in Ethiopia with a TFR of 4.8 overall—urban TFR is 2.6 and the rural TFR is 5.5.[11] The contraceptive prevalence rate (CPR) for any method (modern and traditional) among currently married women in Ethiopia aged 15-49 increased from 15% in 2005 to 29% in 2011; and the CPR for modern methods increased from 13.9% in 2005 to 27.3% in 2011[12];[13]. The trends in CPR use are shown in the graph below. The sharp increase in CPR is thought to be due to the HEP.[14]

FIGURE 1: TRENDS IN CONTRACEPTIVE PREVALENCE (2000-2011)



Working through the HEP is a key strategy that the GoE is using to meet the MDG goals. Under the HEP, the FMOH supports the provision of a range of FP methods (short acting methods and

[10] CIA. The World Fact book. Ethiopia. Available from: https://www.cia.gov/library/publications/the-world-factbook/geos/et.html

[11] Central Statistics Authority [Ethiopia] and ORC Macro. 2011. Ethiopia Demographic and Health Survey 2011. Addis Ababa, Ethiopia and Calverton, Maryland, USA: Central Statistics Authority and ORC Macro.

[12] Central Statistics Authority [Ethiopia] and ORC Macro. 2005. Ethiopia Demographic and Health Survey 2005. Addis Ababa, Ethiopia and Calverton, Maryland, USA: Central Statistics Authority and ORC Macro

[13] Central Statistics Authority [Ethiopia] and ORC Macro. 2011. Ethiopia Demographic and Health Survey 2011. Addis Ababa, Ethiopia and Calverton, Maryland, USA: Central Statistics Authority and ORC Macro.

[14] Central Statistics Authority [Ethiopia] and ORC Macro. 2011. Ethiopia Demographic and Health Survey 2011. Addis Ababa, Ethiopia and Calverton, Maryland, USA: Central Statistics Authority and ORC Macro.

Implanon) by HEWs at the HP level and the revitalization of the IUCD provision by providers at health centers and hospitals. As the national health management information system (HMIS) is currently being rolled out in Ethiopia, little information is available to document progress towards the FP MDGs goals.

OBJECTIVES

The main objective of this study was to assess the readiness of the health system in the selected sites to expand FP service delivery, particularly long acting and permanent methods (LAPMs).. Specific objectives were to:

1. To describe the constellation of FP services that are available from the hospital to the community level including the health system structure and other important factors.
2. To describe the human resources available for service provision including numbers of trained staff, trainings and skills, workload, record keeping, provider perspective, and supervision and knowledge, attitudes, and practices (KAP).
3. To describe the supplies and commodities available at service delivery points including the logistics system and transportation service.
4. To describe the physical infrastructure available to deliver services including the physical structures, electrical and water availability, and other important factors.
5. To describe client perspectives of services including knowledge, attitudes, and practices (KAP), information, education, and communication (IEC), and description of services.

METHODS

SITUATION ANALYSIS OVERVIEW

The Situation Analysis uses a cross sectional design to obtain information about facilities and from clients, providers, and observations from a sample at a single point in time. The Situation Analysis methodology was developed and validated by the Population Council in the 1990s.[15] Situation Analysis is a comprehensive and standardized approach for systematically assessing both the readiness of FP/reproductive health (RH) programs to deliver services and the quality of care received by clients. The Situation Analysis approach grew out of a perceived need on the part of program managers to know the actual state of their programs at the field level. The Situation Analysis methodology investigates the supply side of family planning service delivery by examining the way FP services are organized, delivered, and perceived by clients. The purpose of a Situation Analysis is to examine the readiness and functionality of a system to take on or expand FP services. Since the methodology was developed, it has been used in numerous countries and the results have provided important information to guide policy and programmatic decisions. This methodology was chosen because it is a tested, validated, and relatively inexpensive methodology for describing FP service delivery, and it provides results that are utilizable by program planners and implementers to improve programs.

STUDY DESIGN

This Situation Analysis used a cross-sectional design to obtain information about facilities, providers, and clients through interviews and observations. The data were collected using: a structured interview guide for provider interviews; an exit interview questionnaire for FP clients; facility inventory form for facility infrastructure, FP services, human resources, equipment and commodities data; and an observation guide to collect data from the interaction between FP providers and their clients.

STUDY SAMPLE AND PARTICIPANTS

The FMOH was interested in information from the initial woredas targeted under the IUCD revitalization intervention. At the time of the study design, complete data were only available for 94 out of the 116 woredas targeted by the FMOH. The sample woredas were therefore drawn from these 94 eligible woredas whose data were complete (Appendix 1). The sample was stratified by

[15] Miller R, Fisher A, Miller K, et. al. The Situation Analysis Approach to Assessing Family Planning and Reproductive Health Services: A Handbook. 1997. The Population Council, New York.

region and a random sample of 30 woredas (Appendix 2) were selected proportional to the number of eligible woredas in each region. Within the selected woredas, a purposive sample of health facilities was selected based on accessibility. Up to one hospital, two health centers, and two health posts per woreda were selected for inclusion in the study by the data collection team supervisor with the woreda health office Head. The study team aimed to select one hospital, two health centers, and two health posts per woreda, however this was not possible for hospitals due to their limited availability.

At each facility, up to three staff who routinely provide FP services and were on duty at the time of the visit were eligible for inclusion into the provider study sample. Interactions between providers and clients were also observed. Observation clients were recruited into the study as they arrived at the MCH/FP unit, and consent was sought both from the providers and the clients prior to observing their interaction. For the exit interview, all FP clients between ages 15 and 49 exiting the facility on the day of data collection were eligible for inclusion in the study. Clients were intercepted after receiving their FP services, and the target was to interview up to six new and six return clients; however, due to the low number of clients coming for FP services, it was not possible to achieve these targets. As a result, virtually all FP clients who received services during the survey date were selected and interviewed. An effort was made to interview the same clients who were observed during the provider-client interaction, however not all observed clients consented to being interviewed.

DATA COLLECTION

Data collection took place over a four-week period from May to June 2011. Data were collected by nine teams with three data collectors per team (two male and one female). A supervisor was assigned to each team. All data collectors had medical training and mostly consisted of nurses, health officers, and public health professionals. Prior to deployment to the field, the data collectors and their supervisors received one week training on research ethics, data collection tools, and procedures. The training took place from May 23rd-27th, 2011.

The teams of data collectors were deployed simultaneously to woredas clustered near each other or along the same road in order to facilitate easier access and limit lengthy travel to sites. Each team was assigned 3-4 woredas, and in each woreda they collected data in one facility each day. While at the facility, a female data collector was assigned to observe providers delivering FP services, while the two male data collectors conducted the facility inventory and the provider and client exit interviews. All components of the study (provider interviews, inventory, observation, and exit interviews) were done simultaneously depending on availability of the providers and the client

flow. The procedures used to collect data—facility inventory, provider interview, client exit interview, and a client-provider observation—are described further below.

Facility Inventory

Data collectors used a structured data collection tool to interview the facility manager and to record inventory data for services available at the facility. Specific essential items investigated included: equipment, supplies, materials, and commodities. The functioning of several subsystems, including physical infrastructure, staffing, IEC materials, logistics, management, supervision, and recordkeeping were also assessed. A total of 113 facilities were surveyed in the six study regions.

Provider Interview

During the provider interviews, the data collectors used a structured data collection tool to interview FP service providers who were on duty at the time of the survey. At each health facility, up to three staff who routinely provided FP services and were on duty at the time of the survey were interviewed. Data were collected on the provider training, provision of FP, supervision, and provider perspectives on delivering FP services. In total, 181 providers were interviewed in 6 regions.

Client Interview

Data collectors used a structured data collection tool to interview FP clients as they exited the facility. Data collected pertained to the client's experiences seeking and receiving FP services in the past and at the facility the day of interview. Also clients were asked about their knowledge and attitudes towards FP and their perception of the community knowledge and attitudes. The data collectors interviewed 457 FP clients in the six regions visited.

Client-Provider Observation

A data collector unobtrusively observed sessions with providers and consenting FP clients to collect information on the interaction using a structured observation guide. Data were collected on the counseling, screening, and method provision. The data collectors observed a total of 458 client-provider interactions during the course of the study.

Data Analysis

Data entry, using Epi-Data v3.1 software, began as the data was received at the FMOH. Data analysis was conducted with SPSS v18 and Stata v10.0 statistical software by FMOH and FHI 360 staff. Because the study was descriptive and involved purposive sampling, data analyses included reporting of frequencies, proportions, and/or means for the variables of interest. Data were

analyzed to respond to the objectives of this research. The first section describes the sample characteristics (health facilities, providers, and clients). Subsequent sections include analysis and presentation of data on provider skills, service delivery infrastructure, and FP service delivery—including methods usually provided at the health facilities and methods dispensed to clients. The analysis also examined FP quality of care and client's knowledge and beliefs about FP methods.

DATA QUALITY MANAGEMENT

The rigorous training of the selected data collectors and their supervisors was the first main step towards ensuring data quality. The training included research ethics, sampling, data collection procedures, and data collection instruments. This training lasted one week and included role plays, mock-interviews and a pilot test. During the pilot test, which lasted one day, data collectors were sent to collect data from health facilities within Addis Ababa. Another key approach used to ensure data quality was assigning one supervisor to every three data collectors. This allowed closer supervision and monitoring of the data quality on a daily basis. The supervisors worked closely with the FHI 360 staff to review progress in field work and to correct any identified data quality issues. Following the completion of field work, the supervisors and FHI 360 staff conducted a pre-data entry editing of questionnaires, and during data entry and analysis, conducted consistency checks, validity checks on any outliers, and variable transformations to correct for any inconsistencies in following of the skip patterns and to create new variables for analysis.

ETHICAL CONSIDERATIONS

The study was reviewed and approved by both the Ethiopian Public Health Association (EPHA) Institutional Review Board and the FHI 360 Protection of Human Subjects Committee (PHSC).

FINDINGS

CHARACTERISTICS OF THE SAMPLES (HEALTH FACILITIES, PROVIDERS, AND CLIENTS)

HEALTH FACILITIES DISTRIBUTION BY REGION

The health facilities visited included 11 hospitals, 60 health centers, and 42 health posts. The largest number of health facilities surveyed were in Oromiya (37) and SNNP (29) regions (Table 1).

TABLE 1: DISTRIBUTION OF SAMPLED HEALTH FACILITIES BY REGION

Region name	Total (n)	Hospital (n)	Health Center (n)	Health Post (n)
Tigray	11	3	6	2
Amhara	24	3	11	10
SNNP	29	0	16	13
Oromiya	37	3	19	15
Addis Ababa	7	1	6	0
Diredawa	5	1	2	2
Total number of facilities	**113**	**11**	**60**	**42**

CHARACTERISTICS OF PROVIDERS INTERVIEWED (MCH/FP STAFF)

The facility staff interviewed worked at the MCH/FP units. Because of the low number of hospitals in the sample, data were analyzed combining hospitals and health center staff. This decision was also based on the fact that there were no major differences in the characteristics of the hospital and health center staff. A total of 182 staff were interviewed in the 113 selected health facilities. Most of the facilities had only one staff member, but a few had two or three staff working in the MCH/FP clinic.

Overall, 65% of the providers interviewed were nurses or health officers, and 35% were HEWs. While health posts are generally run by HEWs with a 10th grade education plus one year training in the health extension package, one health post actually had a nurse/health officer running it. Similarly, while HEWs are supposed to work in health posts, three of the MCH/FP providers interviewed at the hospitals/health centers had a HEW qualification. MCH/FP providers were mostly female (86%), and as expected, all providers at the health posts were female. Over half of the providers were married (57%) and 40% were divorced/separated. In terms of religion, the majority of providers were Christians (57% Ethiopia Orthodox and 28% of other Christian denominations) and 15% were Muslim. Results also showed that the providers were generally young, aged 20-29, with nearly all HEWs (98%) being in the 20-29 age bracket. The average age of

the providers at hospitals and health centers was 28.3 compared with 23.2 at the health posts. Other details of the provider's characteristics can be seen in Table 2.

TABLE 2: PROVIDER'S DEMOGRAPHIC CHARACTERISTICS BY FACILITY TYPE

Demographics	Total		Hospital/Health Center		Health Post	
	(n)	(%)	(n)	(%)	(n)	(%)
Provider designation/qualification						
Nurse/Health officer	120	65	119	98	1	2
HEW	65	35	3	2	62	98
Sex						
Male	26	14	26	22	0	0
Female	156	86	93	78	63	100
Marital Status						
Married	104	57	63	53	41	65
Divorced/ separated	73	40	52	44	21	33
Widowed	5	3	4	3	1	2
Religion						
Ethiopian Orthodox	104	57	70	59	35	54
Other Christian	51	28	33	28	17	27
Muslim	27	15	16	13	11	18
Age (years)						
20-29	144	79	82	69	62	98
30+	38	21	37	31	1	2
Mean age (years)	**-**	**26.5**	**-**	**28.3**	**-**	**23.2**
Total number and percent of providers	**182**	**100**	**119**	**100**	**63**	**100**

CHARACTERISTICS OF FP CLIENTS

The data presented here come from the exit client interviews. Nearly all FP clients (94%) were married. This was particularly the case with health post clients where 97% were currently married. The majority of the clients either had no formal education (42%) or only had some primary education (31%). Among health post clients, 55% had no formal education and 37% had some primary education, compared with 39% and 29%, respectively, among FP clients in hospitals and health centers. In terms of reading proficiency, 40% could read easily in their local language while 17% could read with difficulty. A large percentage of the clients (51%) were Ethiopian Orthodox Christians, while 26% were Protestant Christians and 23% were Muslim. Most of the health post clients (47%) were Protestant Christians, but only 21% of the hospital and health center clients were Protestant Christians. In terms of age, more than half of the clients were aged 20-29, and 27% were between the ages of 30-39. Only 10% were aged 15-19. Comparing hospital and health center

clients versus health post clients on age, the health post clients were slightly older (mean age 25.9 in hospitals and health center clients and 27.1 in health posts clients).

TABLE 3: DISTRIBUTION OF CLIENT DEMOGRAPHIC CHARACTERISTICS BY FACILITY TYPE

Demographics	Total		Hospital/ Health Center		Health Post	
	(n)	(%)	(n)	(%)	(n)	(%)
Marital Status						
Married	428	94	333	93	95	97
Single	25	5	23	6	2	2
Widowed	4	1	3	1	1	1
Education						
No education	194	42	140	39	54	55
Some primary	140	31	104	29	36	37
Completed primary	36	8	30	8	6	6
Some secondary	38	8	37	10	1	1
Completed secondary or above	49	10	48	13	1	1
Reported reading proficiency (local language)						
Easily	185	40	163	45	22	22
With difficulty	78	17	56	16	22	23
Not at all	194	43	140	39	54	55
Religion						
Ethiopian Orthodox	233	51	199	55	34	35
Muslim	104	23	86	24	18	18
Protestant	120	26	74	21	46	47
Age (years)						
15-19	46	10	38	11	8	8
20-24	130	28	104	29	26	27
25-29	132	29	108	30	24	25
30-34	74	16	57	16	17	18
35-39	48	11	33	9	15	15
40-44	16	4	12	3	4	4
45-49	9	2	7	2	2	2
Mean age of clients (years)	**-**	**26.6**	**-**	**25.9**	**-**	**27.1**
Parity (living children)						
0	47	11	41	11	6	13
1-3	269	60	226	63	43	44
4-6	109	24	74	21	35	36
7+	22	5	18	5	4	14
Mean number of living children	**-**	**2.7**	**-**	**2.4**	**-**	**3.8**
Total number and percent of clients	**457**	**100**	**359**	**100**	**98**	**100**

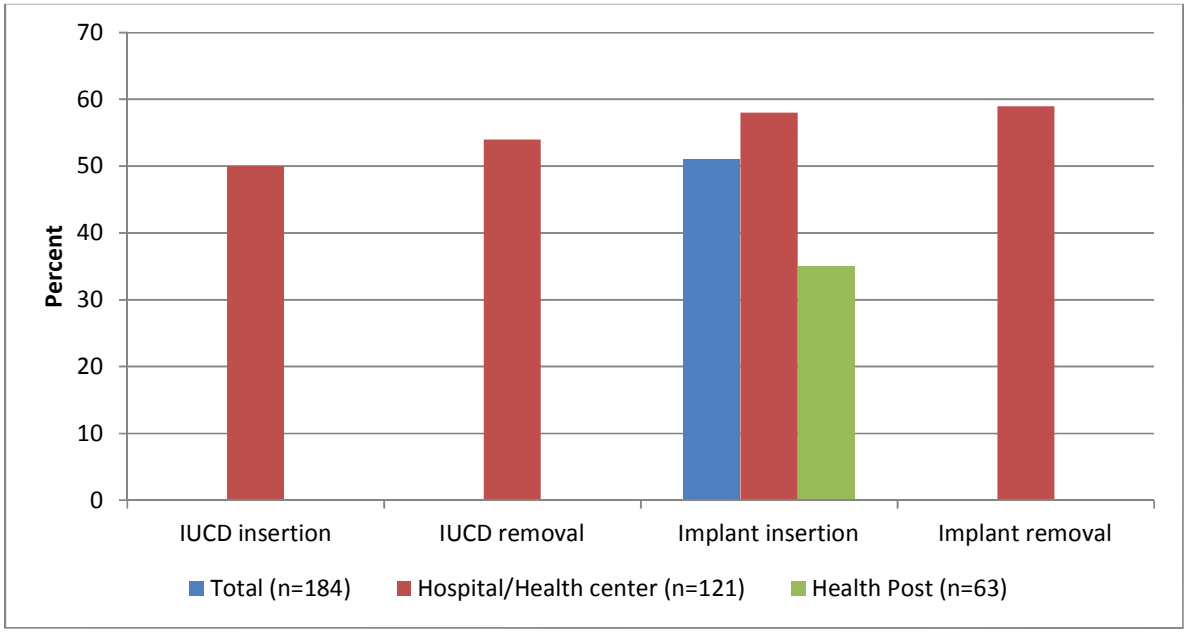
Skilled Personnel, Infrastructure, Equipment and Operations

Availability of trained IUCD and implant providers

IUCD insertion and removal training was only measured among hospital and health center staff as IUCD services in health posts is not authorized. Training in implants insertion, however, was measured among all providers because of the ongoing training of HEWs in Implanon insertion.

Nearly half of the hospital and health center staff reported having received training in IUCD insertion, and just over half (52%) had received training in IUCD removal. Some health extension workers (37%) had received training in implants insertion. Among the hospital and health center staff, 59% reported having been trained in in implant insertion, and 58% also said they had been trained in implant removal.

Figure 2: Type of training received by providers in implant/IUCD Insertion/removal by facility type



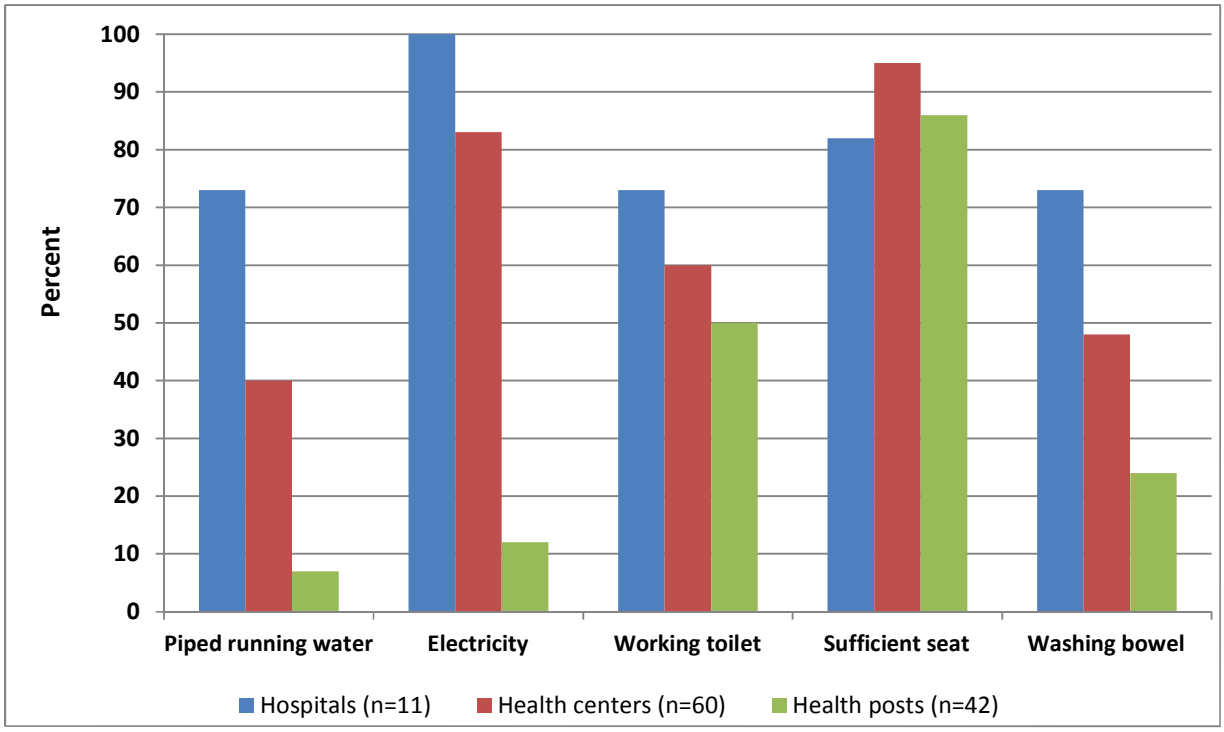
Availability of FP service delivery infrastructure and equipment

In this section, we describe the results related to the availability of basic infrastructure for FP service delivery and the appropriateness of the health facility environment for FP service delivery in the medical examination areas. These data were collected using the facility inventory.

BASIC FP SERVICE DELIVERY INFRASTRUCTURE

Elements of basic infrastructure investigated included: piped running water, electricity, working latrines, seating space, and hand washing bowls with water. Results show that all hospitals, over 80% of health centers and just over 10% of health posts had electricity. Over 80% of all health facilities surveyed had sufficient seating space, especially in health centers where 95% of the facilities were found to have sufficient seating space. Over 70% of the hospitals had piped running water in the FP/MCH unit, but only 40% of the health centers and less than 10% of the health posts also had piped running water. Washing bowls were also available in 70% of the hospitals and in nearly 50% of the health centers, but were less available in health posts (22%). Additionally, working toilets, assessed based on observations of the condition of the toilets by the data collectors, were available in 72% of the hospitals, 60% of the health centers and 50% of the health posts. Overall, except for sufficient seating space, most health posts lacked the basic infrastructure for FP service delivery.

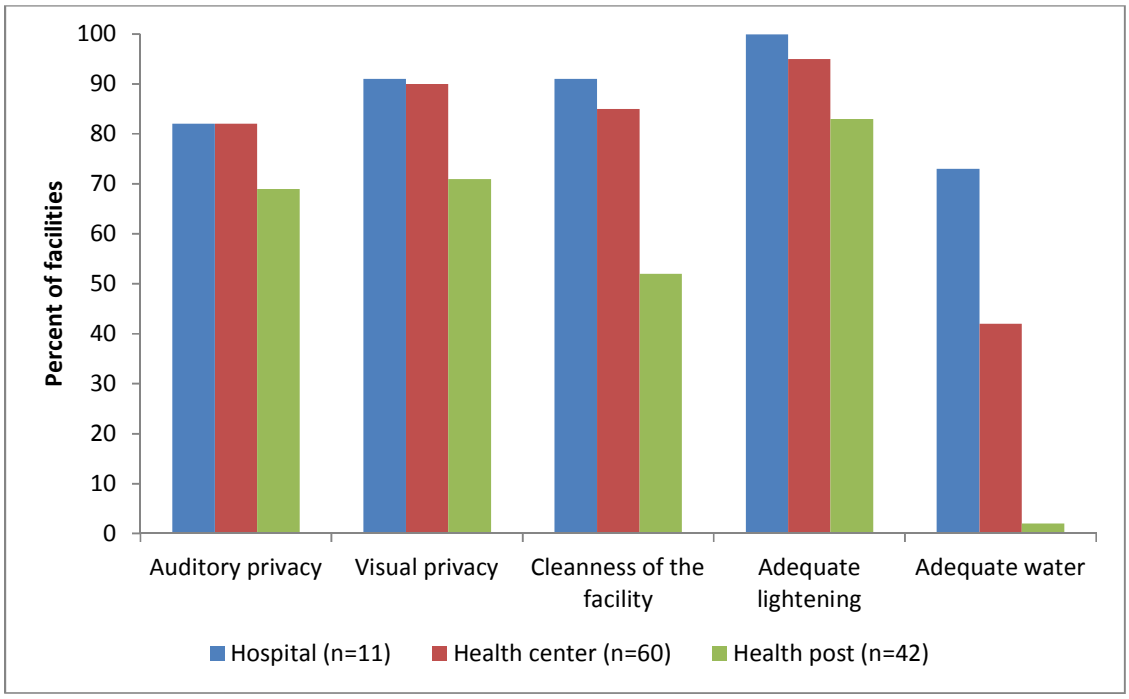
FIGURE 3: BASIC ELEMENTS OF INFRASTRUCTURE BY FACILITY TYPE



Medical examination areas

Generally, hospitals and health centers had good conditions in the medical examination areas. Adequate lighting, visual privacy, cleanliness, and auditory privacy were the areas where hospitals and health centers scored highest. However, water adequacy seems to be a problem, with less than 5% of the health posts (one health post), and less than half of the health centers FP/MCH units reportedly having adequate water. Health posts scored higher on other parameters (adequate light, cleanliness, visual and auditory privacy).

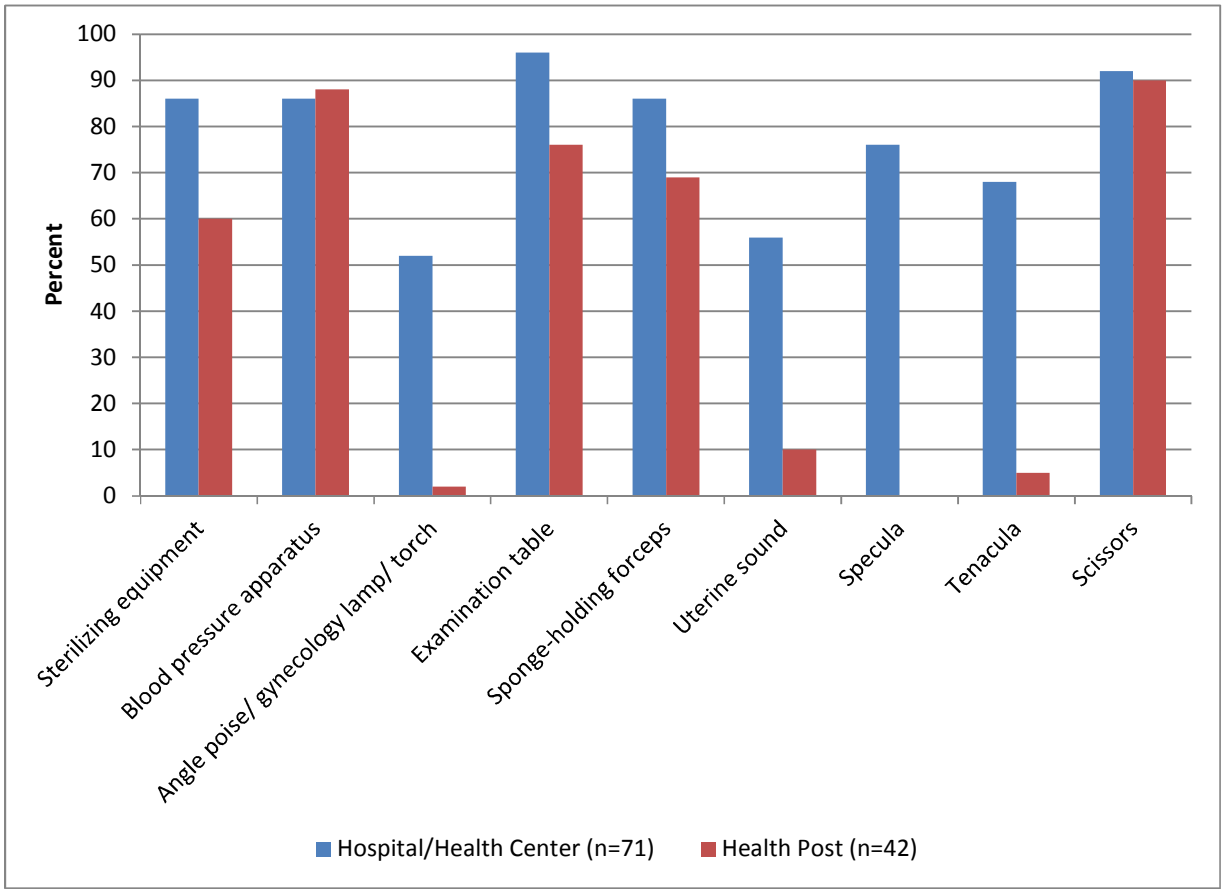
FIGURE 4: CONDITIONS IN MEDICAL EXAMINATION AREAS BY FACILITY TYPE



FP SERVICE DELIVERY EQUIPMENT FOR LONG ACTING METHODS

Most hospitals and health centers had equipment for delivery of long acting FP methods. As shown in Figure 5, the main equipment that was available in over 70% of the hospitals and health centers included: examination tables, scissors, sterilizing equipment, blood pressure apparatus, sponge holding forceps, and specula. In health posts, 90% had scissors, 88% had blood pressure apparatus, 76% had examination tables, and 69% had sponge holding forceps. The least available items in health posts included: angle poise/ gynecology lamps/ torch, specula, tenacula, and uterine sounds.

FIGURE 5: FP SERVICE DELIVERY EQUIPMENT AVAILABILITY BY FACILITY TYPE

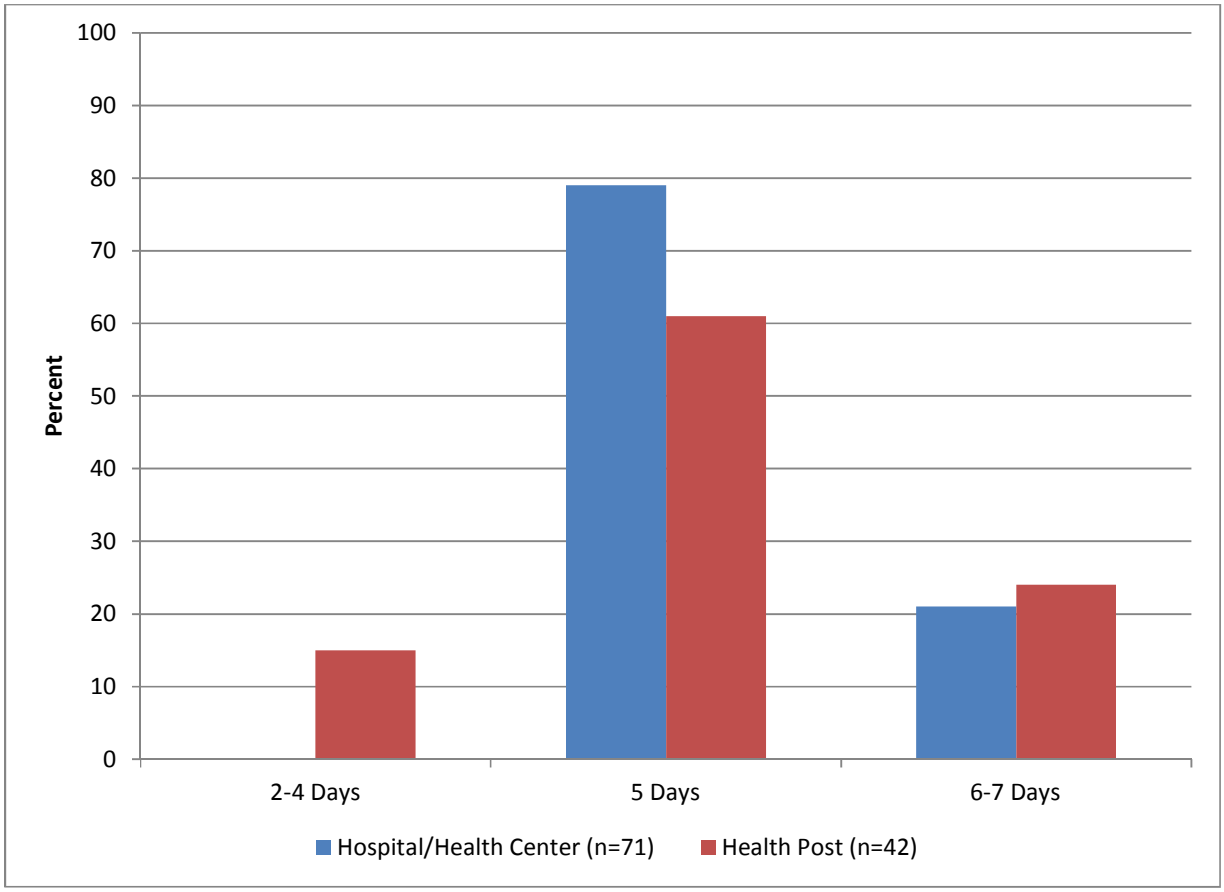


HEALTH FACILITY OPERATIONS

NUMBER OF DAYS PER WEEK THAT FP SERVICES ARE PROVIDED

Figure 6 shows the number of days in a week that the facilities reportedly offer FP services. Providers in 79% of hospitals and health centers said they offered FP services five days in a week, and the remaining 21% offered FP services 6-7 days a week. Health posts had more variations in the days when FP services were offered, but 61% of them reported offering FP services five days a week and another 24% of health posts said they offered FP 6-7 days in a week. The other 15% of the health posts reported offering FP services 2-4 times a week.

FIGURE 6: NUMBER OF DAYS FP SERVICES ARE PROVIDED BY FACILITY TYPE



PERCEPTION OF CONVENIENCE OF THE FACILITY OPERATING HOURS, MEANS OF TRANSPORT, AND AVERAGE TIME TO REACH THE HEALTH FACILITY

Table 4 shows the results regarding client's perception of the convenience of the facility operating hours, the means of transport to travel to the health facility, and the average time taken to reach the health facility. These data are from the exit interviews with FP clients. We separate the responses of hospitals clients from those of the health centers clients because the geographic proximity of hospitals is much lower than the health centers.

Results show that virtually all FP clients considered their health facility operating hours to be convenient. The majority of clients walked to the health facility, particularly those in health posts and health centers—only 11% of all clients used other means (mostly car or horse cart) to come to the health facility. While the clients estimation of the time it took them to travel to their health facility may not necessarily be accurate considering that they may not have timed their trip, results however show that clients were more likely to report a shorter average time to walk to the health

posts (36 minutes average) compared with the time taken to reach hospitals (46 minutes average) and health centers (47 minutes average).

TABLE 4: PERCEPTION OF CONVENIENCE OF FACILITY OPERATING HOURS AND MEANS OF TRANSPORT USED TO THE FACILITY BY FACILITY TYPE

	Total		Hospital		Health Center		Health Post	
	(n)	(%)	(n)	(%)	(n)	(%)	(n)	(%)
Convenience of operating hours								
Percent of clients reporting that facility operating hours are convenient	442	97	62	98	283	96	97	99
Means of transport								
Walked	405	87	46	71	262	89	97	99
Used other means (cars, horse cart)	52	11	18	28	33	11	1	1
Average time to the facility (in minutes)								
Walking	-	45	-	46	-	47	-	36
Other (car, horse cart)	-	34	-	31	-	31	-	34
Total number of clients	**457**	**-**	**64**	**-**	**295**	**-**	**98**	**-**

PROVIDER PERCEPTION OF WORKLOAD

The findings presented here are based on provider perceptions of their workload. A better measurement of workload would require a more defined methodology which includes a review of records, on-site observation of health providers delivering services and activity analysis. Such a study would have to be carried out over a number of days within a typical service delivery week, and preferably repeated at some point in the year to make a better informed judgment of provider workload. The findings reported here should therefore be treated as limited but illustrative of a need for a further study focused on assessing the workload of providers.

Overall, less than half of all providers reported having too much work to do. HEWs were, however, more likely to report having too much work than the nurses and health officers working in the hospitals and health centers (62% and 33% respectively). Most (62%) nurses and health officers stated that their workload was manageable. Very few providers (4%) stated that they did not have enough work.

TABLE 5: PROVIDER'S PERCEPTION OF WORKLOAD BY TYPE OF HEALTH PROFESSIONAL

Perception of workload	Total		Nurse/Health Officer		HEW	
	(n)	(%)	(n)	(%)	(n)	(%)
Too much	79	43	40	33	39	62
Manageable	98	53	75	62	23	37
Not enough work	7	4	6	5	1	1
Total number and percent of providers	**184**	**100**	**121**	**100**	**63**	**100**

SUPERVISION

Findings show that 89% of the providers interviewed at health posts, and 72% of the providers interviewed at hospitals and health centers, had received a supervisory visit within the past three months. A majority of the providers also felt that their supervisors were available to help them whenever they needed help.

TABLE 6: SUPERVISORY VISIT WITHIN THE PAST THREE MONTHS BY HEALTH FACILITY TYPE AND PROVIDER PERCEPTION OF THE AVAILABILITY OF THEIR SUPERVISOR

Supervision	Total		Hospital		Health Center		Health Post	
	(n)	(%)	(n)	(%)	(n)	(%)	(n)	(%)
Received supervisory visit in past 3 months	143	78	12	86	73	81	56	89
Supervisor is available to help when needed	166	90	19	95	87	88	60	90
Number of providers interviewed	**184**	**-**	**20**	**-**	**99**	**-**	**65**	**-**

FP INFORMATION

FP information at the health facilities was investigated in terms of availability of a sign outside, inside, or both inside and outside the building announcing that FP services were provided at the health facility. Seventy-three percent of the hospitals and health centers had a sign announcing availability of FP services at the facilities visited, but only 52% of health posts had a sign.

Results also showed that 89% of the hospitals and health centers, and 83% of the health posts, had at least one IEC material concerning FP, antenatal/post abortion care, delivery services, HIV and AIDS, or other sexually transmitted infections (STIs). The most commonly available subject matter of the IEC material was related to FP (available in 80% of the hospitals and health centers, and in 74% of the health posts).

TABLE 7: FACILITIES WITH A SIGN ANNOUNCING FP SERVICES AND FACILITIES WITH AT LEAST ONE IEC MATERIAL (SIGN, POSTER, BROCHURE, FLIP CHART) ON THE FOLLOWING TOPICS

	Hospital /Health Centers		Health Posts	
	(n)	(%)	(n)	(%)
Sign announcing FP availability of FP services				
Facilities with a sign announcing FP services	52	73	22	52
Availability of at least one IEC material				
Facilities with at least one IEC material on a topic related to FP, ANC, delivery, HIV or STI	63	89	35	83
Topics in IEC material				
Family planning	57	80	31	74
Antenatal care	35	49	15	36
Delivery	21	30	5	12
HIV	38	54	20	48
STI	7	10	2	5
Total number of facilities	**71**	**-**	**42**	**-**

PROVIDER'S EXPOSURE TO AND USE OF FP POLICY GUIDELINES

The findings presented in Table 8 show that only a small percentage of providers in all facility types had seen the national FP policy guidelines. Similarly, a small percentage of providers had attended any trainings, workshops or seminars on FP policy guidelines in the past five years. However, the providers who had seen the policy guidelines were more likely to have read it.

TABLE 8: PERCENT OF PROVIDERS WHO HAVE SEEN AND THOSE WHO HAVE USED THE NATIONAL FP POLICIES AND GUIDELINES

	Hospitals/ Health Centers		Health Posts	
	(n)	(%)	(n)	(%)
Among all providers				
Providers who have seen the national FP guideline	15	12	5	8
Provider who have attended training, workshops, or seminars on National Family Planning Policy Guidelines within the last 5 years	23	19	11	16
Total number of providers	**118**	**-**	**65**	**-**
Among providers who have seen the guidelines document				
Provider has read document	14	93	5	100
Facility has copy of document	8	53	5	100
Number of providers who had seen the guidelines	**15**	**-**	**5**	**-**

FP SERVICE DELIVERY

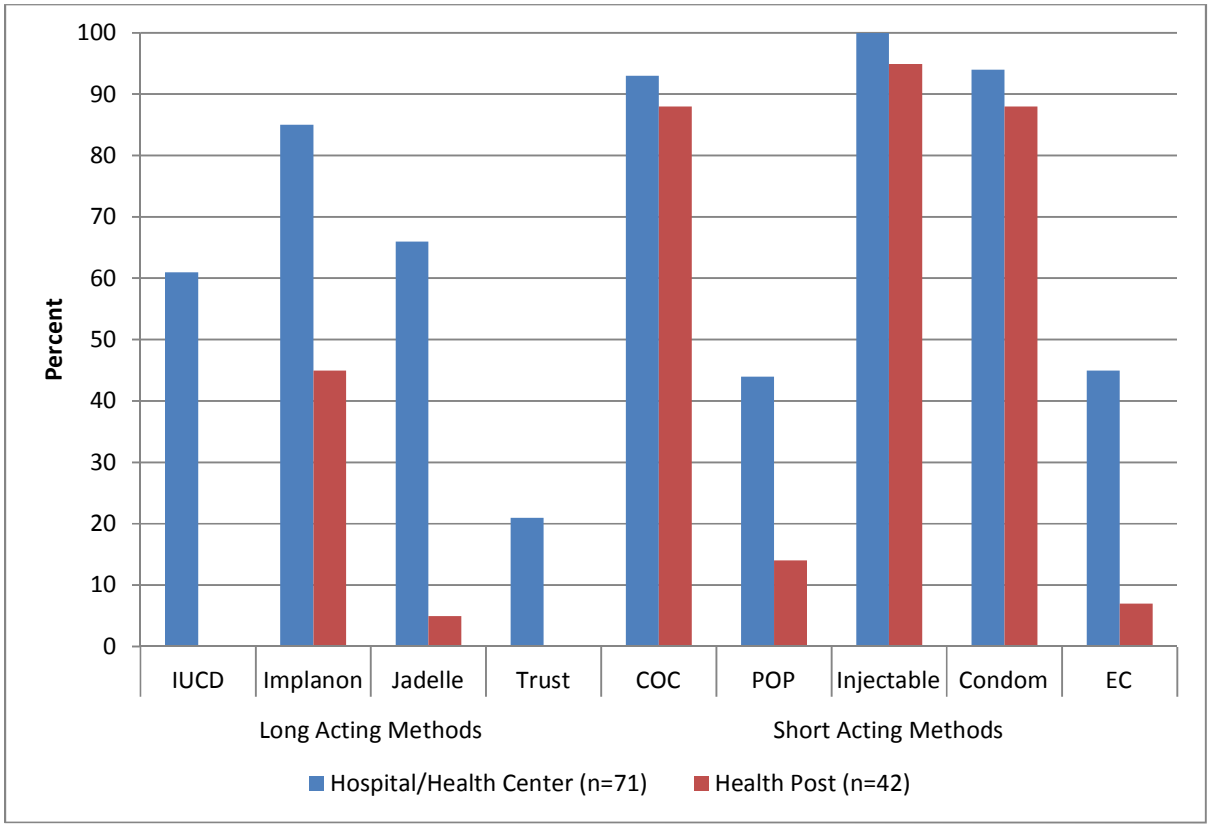
The results presented in this section describe FP service delivery at the facilities surveyed. The results show the level of availability of FP methods and consumables at the health facilities and whether or not clients paid for FP services.

FP METHODS USUALLY PROVIDED AT THE HEALTH FACILITY

Findings on the FP methods *usually* provided at the health facilities surveyed are presented in Figure 7. Among the long acting methods, as expected, none of the health posts provided IUCDs because they are not authorized, but 45% of the health posts reported usually providing Implanon, and another 5% of the health posts providers also said they provide Jadelle implants. While it was not investigated, it is probable that the health posts that reported providing Jadelle did so through the outreach program; otherwise the FMOH does not authorize training of HEWs on Jadelle insertion, neither are they authorized to provide Jadelle insertions. In the hospitals and health centers, findings from the facility inventory indicated that 85% usually provided Implanon, 66% usually provided Jadelle, and 61% usually provided IUCDs. Only 21% of hospitals and health centers reported usually providing Trust implant.

Short-acting methods were generally provided in most facilities. Injectable contraceptives were universally provided in hospitals and health centers and in almost all health posts—95% health posts reported usually providing injectable contraceptives. The combined oral contraceptive (COC) pills were reportedly provided in most of the health facilities—93% hospitals and health centers and 88% health posts said they usually provide the COC pills. Results also show that the majority of health facilities reported usually providing condoms (94% of the hospitals and health centers and 88% of the health posts).

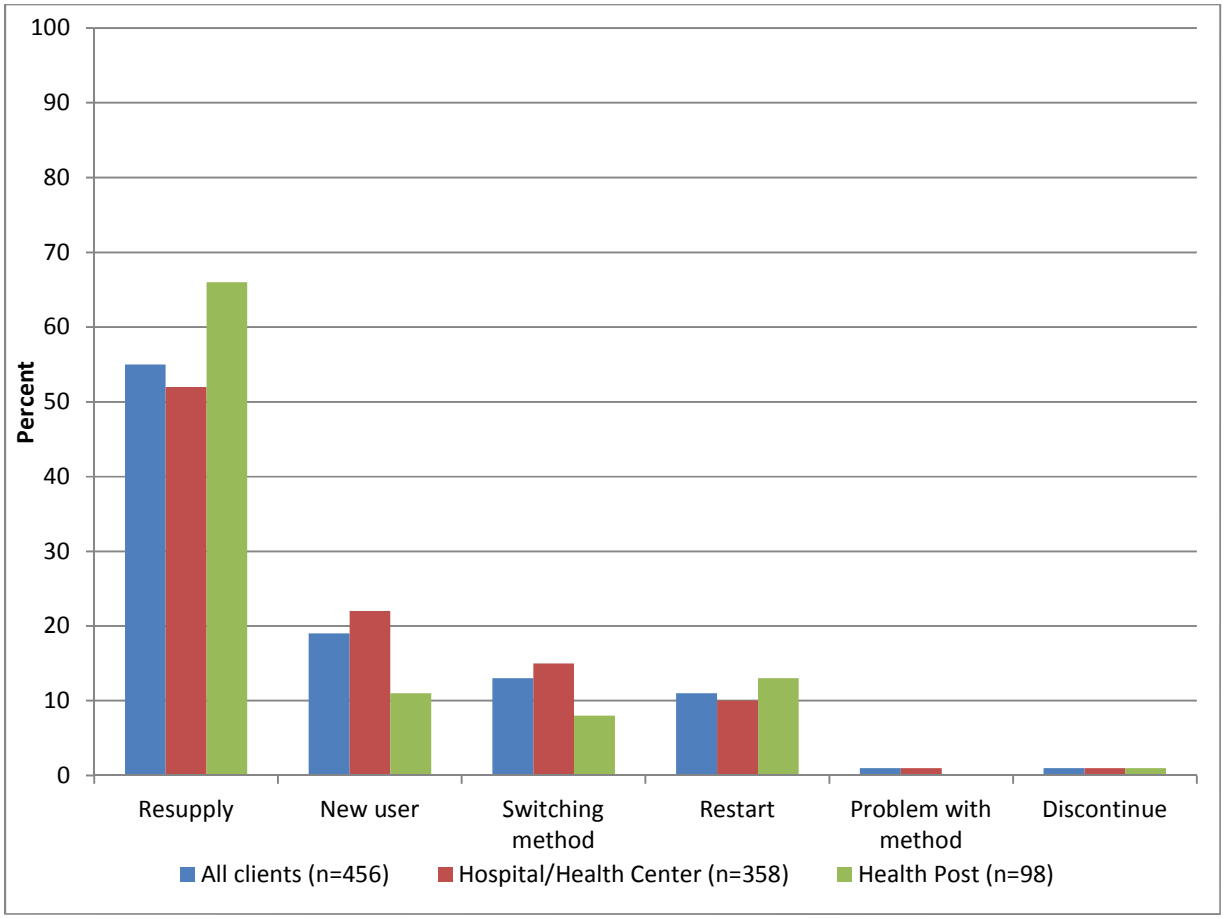
FIGURE 7: PROVISION OF FP METHOD BY FACILITY TYPE



PURPOSE OF CLIENT'S VISIT TO THE HEALTH FACILITY

As shown in Figure 8, the majority of clients sought services in order to obtain a re-supply of their FP method—52% of clients at hospitals and health centers and 66% of clients at health posts sought a resupply of their method. Twenty-two percent of clients came to the hospitals and health centers to start FP (new FP clients), and 11% of health posts clients were new clients. Other results can be seen in Figure 8.

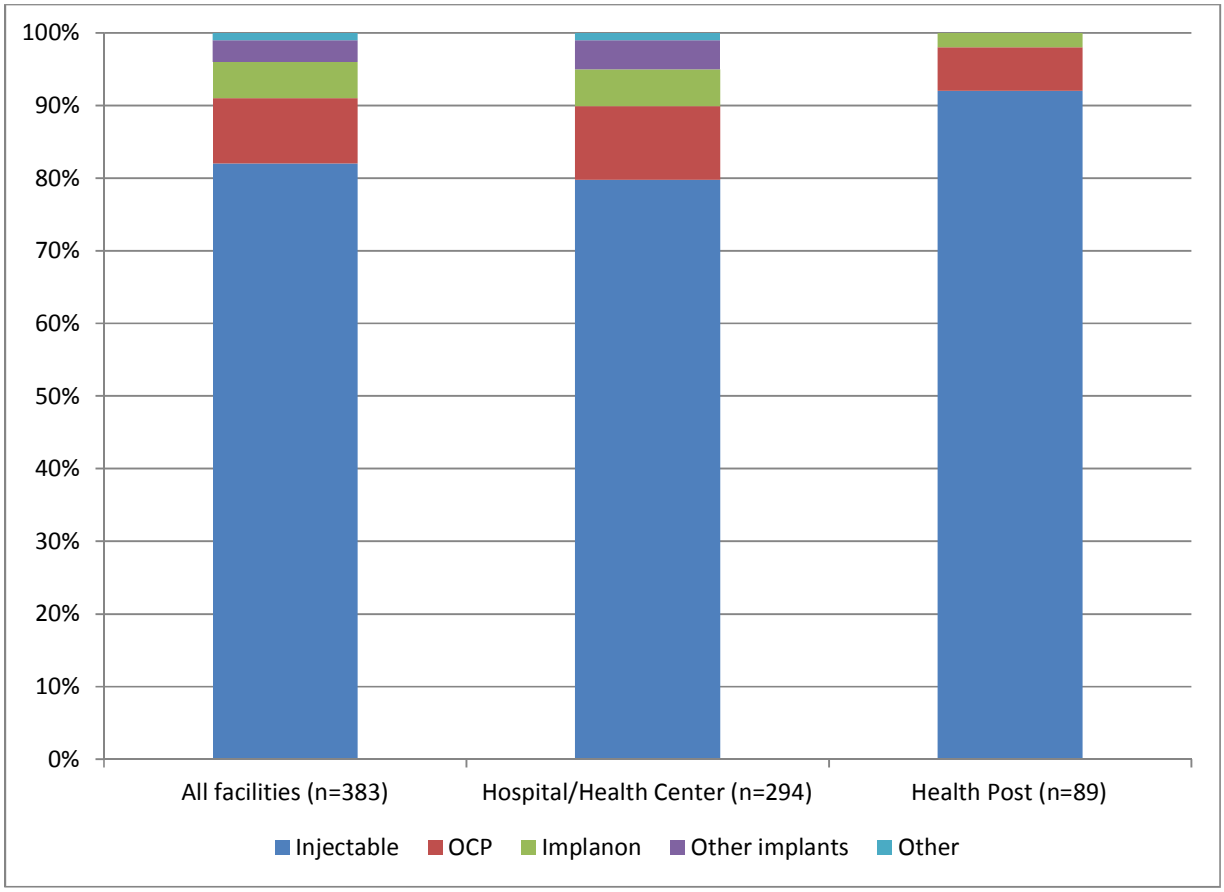
FIGURE 8: CLIENTS' PURPOSE OF VISIT BY FACILITY TYPE



FP METHODS RECEIVED BY THE CLIENTS DURING THEIR VISIT

As indicated in Figure 9, injectable contraceptive was the main method received by most clients (82% of all clients received an injectable contraceptive). Only 9% of the clients received OCPs, 5% received Implanon, and 3% received other implants (which included Jadelle, Norplant, and Trust implant).

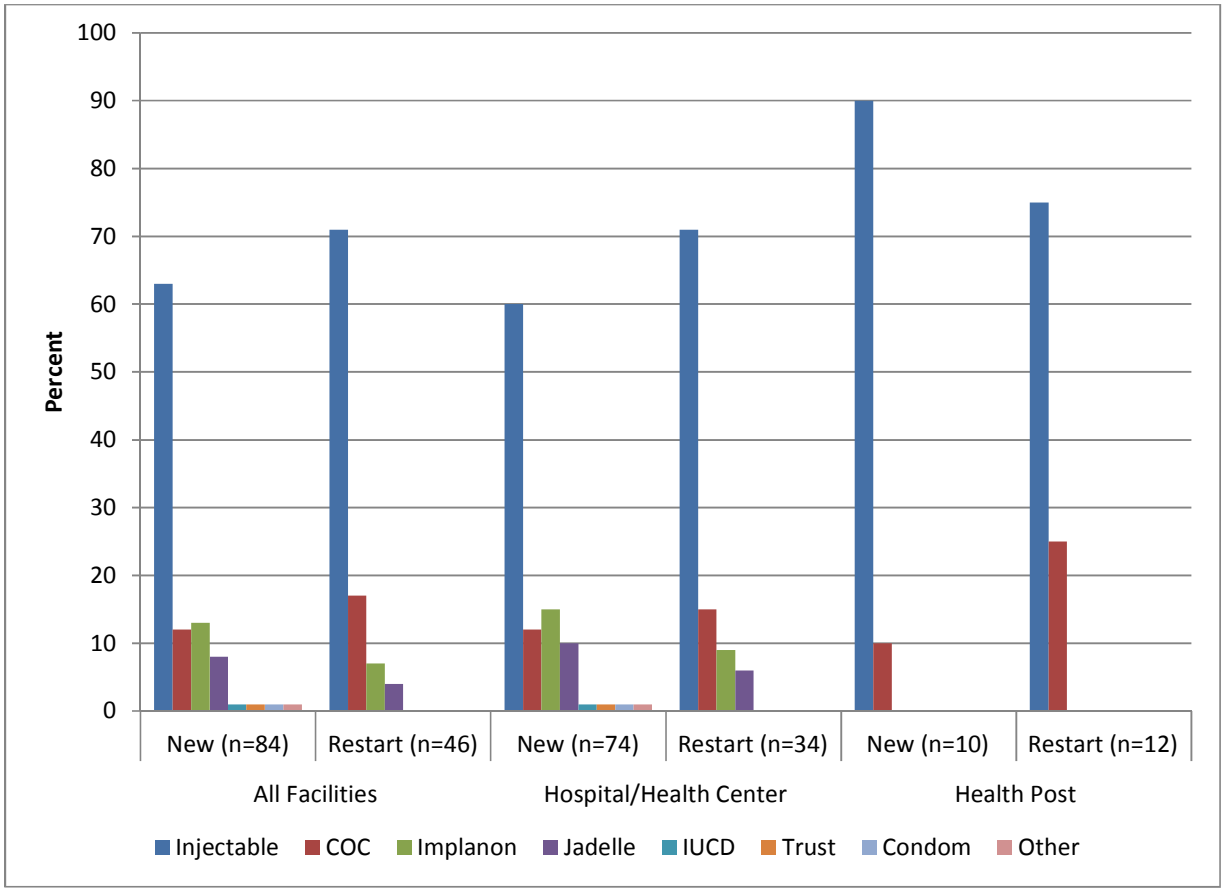
FIGURE 9: PERCENT DISTRIBUTION OF CLIENTS WHO RECEIVED EACH FP METHOD BY FACILITY TYPE



FP METHODS RECEIVED BY NEW AND RESTART FP CLIENTS

During the survey, 84 out of the 457 clients were new clients. As shown in Figure 10, the main method received by the new and restart clients was the injectable contraceptive (63% in the new clients and 71% in restart clients), followed by pills. It is also notable that 13% of the new clients received Implanon.

FIGURE 10: PERCENT OF NEW AND RESTART CLIENTS BY THE METHOD RECEIVED AT THE TIME OF FACILITY VISIT



SUPPLIES AND LOGISTICS MANAGEMENT

NUMBER OF FP METHOD IN STOCK

Table 9 explains the number of different types of FP methods (OCPs, injectable, IUCD, implants, emergency contraception, and condoms) that were available at the time of survey in health facilities. All hospitals and health centers had two or more FP method alternatives available at the time of the survey. The majority (48%) had more than four types of FP methods in stock, with a mean of 4.4. In the health posts, nearly half (48%) had three methods in stock at the time of the survey, and 24% had two methods in stock. The mean method choices available in health posts were 2.7.

All hospitals had at least one long acting family FP methods; 87% of health centers and 50% health posts have access to one long acting FP method. It is important to note that health posts are only allowed to provide one long acting method, Implanon. So, half of the health posts were stocked with Implanon.

TABLE 9: NUMBER OF FP METHODS AVAILABLE AT TIME OF SURVEY BY FACILITY

Number of FP methods available	Hospital/Health Center		Health Post	
	(n)	(%)	(n)	%
None	0	0	1	2
One	0	0	3	7
Two	6	9	10	24
Three	8	11	20	48
Four	23	32	8	19
More than 4	34	48	0	0
Total (number and percent)	**71**	**100**	**42**	**100**
Mean number of methods in stock	**-**	**4.4**	**-**	**2.7**

COMPARISON OF THE AVAILABILITY OF LONG ACTING AND SHORT ACTING METHODS

Table 10 summarizes in general terms the availability of any implant; any long acting method, which included any implant (Implanon, Jadelle, Trust, Norplant), and IUCD; and any short acting method (OCPs, injectables, emergency contraception, and condoms). Findings showed that 89% of the hospitals and health centers, and 48% of the health posts, had an implant in stock at the time of the survey. A similar percent of providers had any long acting method, suggesting that virtually all long acting methods at the health facilities are implants. Short acting methods were available in 100% of the hospitals and health centers, and in 98% of the health posts.

TABLE 10: AVAILABILITY OF ANY IMPLANT, ANY LONG ACTING METHOD AND ANY SHORT ACTING METHOD BY FACILITY TYPE

	Hospital/Health Center		Health Post	
	(n)	(%)	(n)	%
Any implant	63	89	20	48
Any long acting method	63	89	21	50
Any short acting method	71	100	41	98
Total number of facilities	**71**	**n/a**	**42**	**n/a**

STOCK-OUT OF FP PRODUCTS IN THE PAST SIX MONTHS AND AT THE TIME OF THE SURVEY

Data on availability of FP methods were only analyzed based on health facilities that said they usually provided each method.

LONG ACTING METHODS

Among the hospitals and health centers that usually provided IUCD, 93% had had it in stock at the time of the survey. When asked if they had had a stock out of IUCDs within the past six months, 27% reported a stock-out. Implanon was in stock at the time of the survey in 90% of hospitals and health centers that said they usually provide Implanon, but 26% had a stock-out within the past six months. Jadelle was also found in stock at the time of the survey in 85% of the hospitals and health centers that usually provide Jadelle, but 29% had had a stock-out at some point in the past six months. Trust Implant, which was the least available long acting method, was available in stock in all the 15 hospitals and health centers that usually provided it, but three of these health facilities had a stock out at some point in the past six months. In health posts, Implanon was available in stock at the time of the survey in 79% health posts that usually provide it; however, 47% of these health posts reported having a stock-out at some point in the past six months.

SHORT ACTING METHODS

Among the facilities that reported usually providing short acting methods, the majority had the methods in stock at the time of the survey. Data shows that 92% of hospitals and health centers had COCs in stock, but 21% of them had experienced a stock-out within the past six months. Injectable contraceptives were available in 93% of hospitals and health centers, but 18% of them had experienced a stock out in the past six months. In health posts, the most available method in stock was the injectable contraceptive—available in 96% of health posts, but 38% of health posts reported experiencing a stock-out in the past six months. COCs were also in stock at the time of the survey in 84% of health posts, but 16% of health posts had experienced a stock-out in the past six months. More detailed results for other methods are presented in Table 11.

TABLE 11: CONTRACEPTIVE METHODS IN STOCK AND REPORTED STOCK OUTS WITHIN THE PAST SIX MONTHS

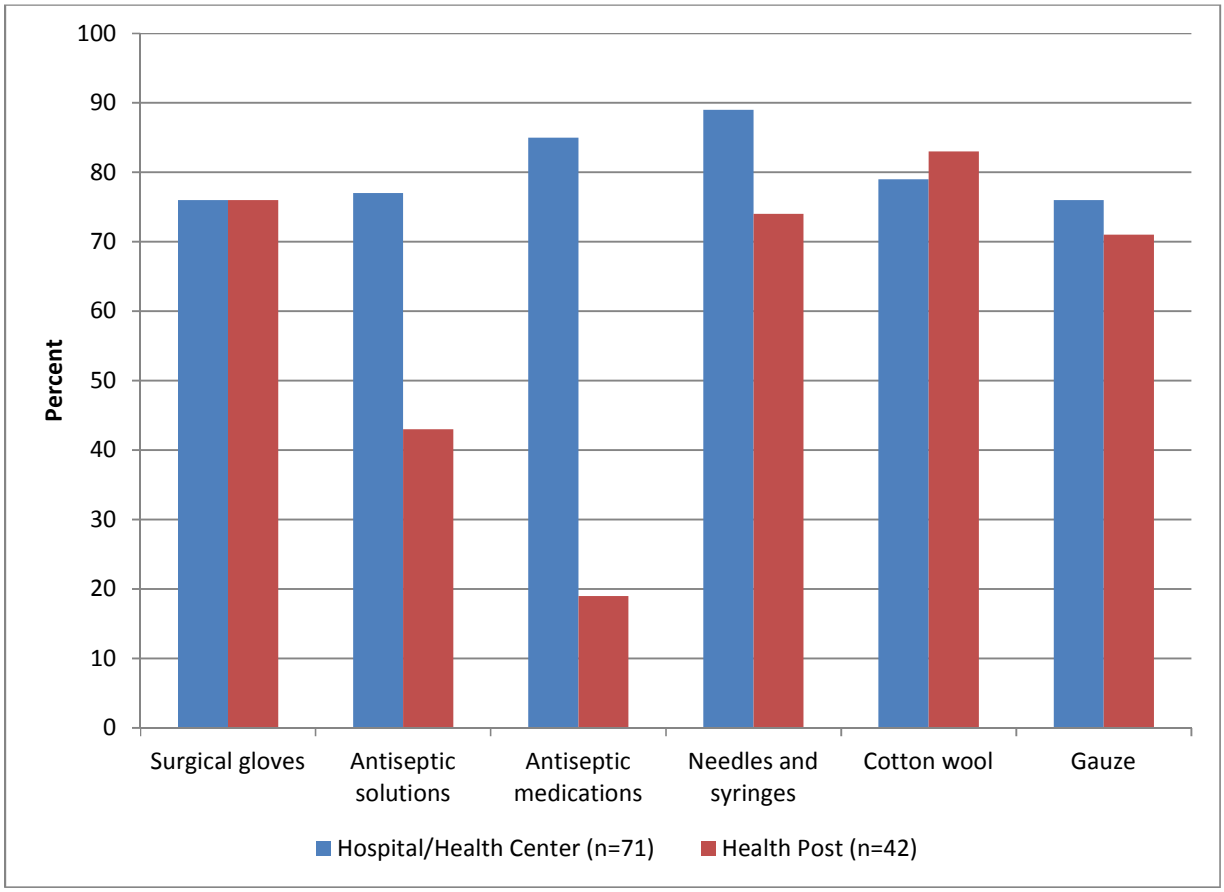
Methods	Hospital / Health Center		Health Post	
	(n)	(%)	(n)	(%)
Long acting methods				
IUCD				
Available at time of survey	40	93	n/a	n/a
Number of facilities that usually provide IUCD	**43**	-	-	-
Implanon				
Available at time of survey	55	90	15	79
Number of facilities that usually provided Implanon	**61**	-	**19**	-
Jadelle				
Available at time of survey	40	85	n/a	n/a
Number of facilities that usually provided Jadelle	**47**	-	-	-
Trust Implant				
Available at time of survey	15	100	n/a	n/a
Number of facilities that usually provided Trust implant	**15**	-	-	-
Short Acting Methods				
Combined Oral Contraceptive Pills				
Available at time of survey	61	92	31	84
Total number of facilities that usually provided COCP	**66**	-	**37**	-
Progestin-only pill				
Available at time of survey	25	81	2	33
Total number of facilities that usually provided progestin only pills	**31**	-	**6**	-
Injectable contraceptive				
Available at time of survey	66	93	39	96
Total number of facilities that usually provided injectables	**71**	-	**40**	-
Condom				
Available at time of survey	59	88	26	70
Total number of facilities that usually provided condoms	**67**	-	**37**	-
Emergency Contraception				
Available at time of survey	26	82	1	33
Total number of facilities that usually provided EC	**32**	-	**3**	-

AVAILABILITY OF CONSUMABLES FOR PROVIDING LONG ACTING FP METHODS

The consumables investigated included surgical gloves, antiseptic solution, anesthetic medication, needles and syringes, cotton wool, and gloves. There were marked differences in the availability of antiseptic solution and anesthetic medication between hospitals and health centers versus health posts, but availability of most of the other consumables was similar. Only 19% and 43% of health posts had anesthetic medication and antiseptic solution, respectively, compared with 85% and 77%

in hospitals and health centers, respectively, but the availability of the rest of the consumables was comparable. Details about availability of consumables can be seen in Figure 11.

FIGURE 11: PERCENT OF FACILITIES WITH CONSUMABLES AVAILABLE IN STOCK BY FACILITY TYPE



WRITTEN INVENTORY FOR FP PRODUCTS

Data on written inventories were analyzed only for facilities that reported usually providing the particular methods. As shown in Table 12, quite a large number of health facilities studied did not have written inventories for FP methods. In hospitals and health centers, 63% had a written inventory for IUCDs; 60% had a written inventory for Jadelle; 58% had a written inventory for injectables; 56% had a written inventory for Implanon; and 53% had a written inventory for OCPs. In the health posts, 53% had a written inventory for injectables; 44% had a written inventory for OCPs; and only 31% had a written inventory for Implanon. Other results can be seen in Table 12.

TABLE 12: PERCENT OF FACILITIES WITH WRITTEN INVENTORIES FOR THE LISTED FP METHODS

FP Method	Hospital /Health centers		Health Posts	
	(n)	(%)	(n)	(%)
OCPs	52 *(n=98)*	53	19 *(n=43)*	44
Injectable contraceptive	41 *(n=71)*	58	18 *(n=40)*	53
IUCD	27 *(n=62)*	63	n/a	NA
Implanon	34 *(n=61)*	56	6 *(n=19)*	31
Jadelle	29 *(n=48)*	60	1 *(n=2)*	50
Trust Implant	10 *(n=71)*	14	n/a	NA
Condom	35 *(n=71)*	49	16 *(n=42)*	38
Emergency Contraception	17 *(n=32)*	53	1 *(n=3)*	33

RECORD KEEPING

Overall, hospitals and health centers were more likely to have well-ordered record card systems than the health posts (82% and 57% respectively). Results also show that 26% of the health posts and 8% of the hospitals and health centers had partially ordered but usable record card systems, but 17% of the health posts and 10% of the hospitals and health centers had disordered and unusable record card systems. In terms of commodity daily registers for MCH-FP services, 52% of the hospitals and health centers and 29% of the health posts had a single register for all MCH-FP services, but most importantly, 31% of the hospitals and health centers, and 55% of the health posts had no daily activity registers for MCH-FP services.

On service statistics reporting, all health facilities reported FP health statistics to their supervisors; 90% of the hospitals and health centers and 98% of the health posts reported service statistics on MCH to their supervisors on MCH, and 82% of the hospitals and health centers and 71% of the health posts reported service statistics on STI/HIV/AIDS to their supervisors.

TABLE 13: CONDITION OF THE RECORD CARD SYSTEM, DAILY ACTIVITY REGISTERS FOR MCH/FP AND RECORD KEEPING SYSTEMS BY FACILITY TYPE

	Hospital/ Health Center		Health Post	
	(n)	(%)	(n)	(%)
Observed condition of the record card system				
Well ordered	58	82	24	57
Partially ordered but usable	6	8	11	26
Disordered and not usable	7	10	7	17
Total number and percent of facilities	**71**	**100**	**42**	**100**
Availability of daily activity register for MCH-FP services				
Single register available for all MCH-FP services	37	52	12	29
Available for some services only	5	7	6	14
Separate registers available for each service	7	10	1	2
No daily activity register for any service	22	31	23	55
Total number and percent of facilities	**71**	**100**	**42**	**100**

REPORTING OF SERVICE STATISTICS TO THE SUPERVISOR

Generally, reporting of service statistics for MCH-FP across all facility types seemed good. All health facilities reported service statistics on FP to their supervisors, and 90% of the hospitals and health centers and 98% of the health posts reported service statistics for MCH to their supervisors. Additionally, 82% of the hospitals and health centers and 71% of the health posts also reported service statistics on STI/HIV and AIDS to their supervisors.

TABLE 14: FACILITY REPORTING OF SERVICE STATISTICS ON MCH, FP AND STI/HIV AND AIDS TO SUPERVISORS

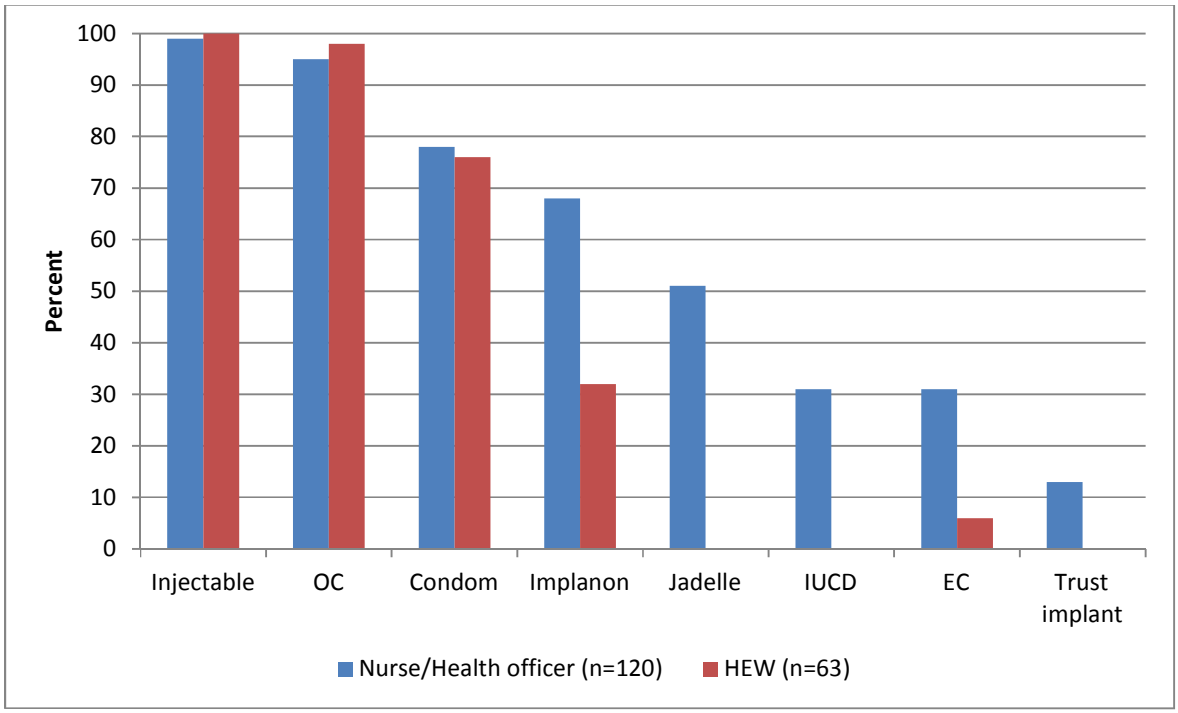
	Hospital/ Health Center		Health Post	
	(n)	(%)	(n)	(%)
Service statistics reported to supervisors				
MCH	64	90	41	98
FP	71	100	42	100
STI/HIV and AIDS	58	82	30	71
Number of facilities inventoried	**71**	**-**	**42**	**-**

QUALITY OF CARE

FP METHODS DISPENSED BY PROVIDERS

Figure 12 shows the responses of providers to a question asking them to name the methods that they had dispensed within the past three months. Virtually all providers in hospitals, health centers, and health posts had personally dispensed injectables and OCPs. The percentage of providers who also reported dispensing condoms within the past three months was similar in hospitals, health centers and health posts (77% of hospitals and health centers providers and 76% of the health post providers). Nearly 70% of the hospitals and health center providers had also inserted Implanon, which was more than twice that of health post providers where 32% of the providers had performed Implanon insertions. Additionally, Jadelle was reportedly inserted by 50% of the hospitals and health centers staff, but only 5% of the health posts providers reported inserting Jadelle—which is understandable given that Jadelle is only approved for insertion in health centers and hospitals.

FIGURE 12: FP METHODS DELIVERED IN THE PAST 3 MONTHS BY TYPE OF HEALTH PROFESSIONAL



QUANTITY OF PILLS DISPENSED TO CLIENTS

Providers were asked the quantity of pills they dispense to clients who had used pills for one or more years. In hospitals and health centers, 52% of the providers (nurses and health officers) said

they dispensed 3-4 cycles at each client visit, and another 41% of providers said they dispensed 1-2 cycles at each visit. Comparatively, HEWs in the health posts dispense a lower number of cycles to clients at each visit, the majority dispensing 1-2 cycles at each visit. However, the tendency to dispense one cycle to clients on their first visit was a common practice with all providers.

TABLE 15: NUMBER OF CYCLES OF OCPS USUALLY PRESCRIBED TO A CLIENT AT EACH VISIT BY PROVIDER TYPE

	Nurse/ Health Officer		HEW	
	(n)	(%)	(n)	(%)
# of OCP cycles routinely supplied to a client who has used the pill for one year or more				
1-2 cycles	47	41	44	72
3 - 4 cycles	60	52	15	25
12+ cycles	9	8	2	3
Number of OCP cycles usually supplied to client on first visit				
1 cycle	102	88	60	98
3 cycles	14	12	1	2
Number of providers interviewed	**116**	**-**	**61**	**-**

PROVIDER'S COMFORT IN CONDUCTING IUCD INSERTIONS

Providers in hospitals and health centers were asked if they had conducted IUCD insertions in the past three months, and for those that had conducted insertions, their comfort level with the procedure was measured. For those who had not conducted IUCD insertions, their reasons for not conducting IUCD insertions were investigated. Despite their comfort level and training to insert IUCDs, all providers were asked about their level of interest in providing IUCDs. The results are summarized in Table 16. Overall, 68% of the providers who had conducted IUCD insertions (hospitals and health centers) said they were very comfortable conducting IUCD insertions, and the other 32% said they were comfortable. For the providers who had not performed any IUCD insertions in the past three months, the lack of training in IUCD insertion was the mostly cited reason for not providing IUCDs. However, the majority of providers in hospitals, health centers, and health posts expressed interest in conducting IUCD insertions. Among hospital and health center providers, 87% said they were either very interested or extremely interested, and in health posts, 82% were either very interested or extremely interested. Despite the interest by HEWs to provide IUCD insertions, the FMOH does not approve training and provision of IUCD insertions by HEWs.

TABLE 16: PROVIDER COMFORT IN IUCD INSERTION, REASONS FOR NOT CONDUCTING IUCD INSERTIONS AND INTEREST IN PROVIDING IUCD BY PROVIDER TYPE

	Nurse/ Health Officer		HEW	
	(n)	(%)	(n)	(%)
Comfort level among providers who have inserted IUCDs in the last 3 months				
Very comfortable	25	68	n/a	n/a
Comfortable	12	32	n/a	n/a
Neither comfortable nor uncomfortable	0	0	n/a	n/a
Uncomfortable	0	0	n/a	n/a
Very uncomfortable	0	0	n/a	n/a
Total number and percent of providers who had inserted IUCD in past 3 months	**37**	**100**	**n/a**	**n/a**
Main reason for not providing IUCD among providers who did not provide IUCDs in the last 3 months				
No training	52	64	n/a	n/a
Method isn't available	1	1	n/a	n/a
Not comfortable providing	0	0	n/a	n/a
Not allowed to provide method	0	0	n/a	n/a
Other	15	18	n/a	n/a
Number of providers who did not provide IUCD in past 3 months	**81**	**-**	n/a	n/a
Providers level of interest in providing IUCDs				
Not at all interested	3	3	2	3
A little interested	4	3	0	1
Moderately interested	9	8	9	14
Very interested	80	67	40	63
Extremely interested	24	20	12	19
Total number of providers in the sample	**120**	**-**	**63**	**-**

PROVIDER'S COMFORT IN CONDUCTING IMPLANT INSERTIONS

Just like the IUCD insertions, providers who had conducted implant insertions in the past three months were asked their comfort level with implant insertion, and for those who had not conducted any insertions, the reasons for not conducting insertions were investigated. Overall, virtually all providers were comfortable with implant insertion. Among nurses and health officers, 65% of the providers said they were very comfortable with inserting implants (79% among HEWs). Lack of training was cited by those who had not conducted insertions, the majority being HEWs. For all providers however, the majority were either very interested or extremely interested in conducting implant insertions.

TABLE 17: PROVIDER COMFORT IN IMPLANT INSERTION, REASONS FOR NOT CONDUCTING IMPLANT INSERTIONS, AND INTEREST IN PROVIDING IMPLANTS BY PROVIDER TYPE

	Nurse/ Health Officer		HEW	
	(n)	(%)	(n)	(%)
Comfort level among providers who have inserted implants in the last 3 months				
Very comfortable	43	65	15	79
Comfortable	21	32	4	21
Neither comfortable nor uncomfortable	1	1	0	0
Uncomfortable	0	0	0	0
Very uncomfortable	1	1	0	0
Total number and percent of providers who inserted implants past 3 months	**66**	**100**	**19**	**100**
Main reason for not providing implants among providers who did not provide implants in past 3 months				
No training	24	48	27	71
Method isn't available	0	0	0	0
Not comfortable providing	0	0	0	0
Not allowed to provide method due to lack of training	0	0	4	11
Other*	7	18	33	38
Total number of providers who did not provide implants past 3 months	**50**	**-**	**38**	**-**
Provider's interest in providing implants				
Not at all interested	2	2	2	3
A little interested	1	1	0	0
Moderately interested	6	5	4	6
Very interested	78	67	38	33
Extremely interested	33	28	63	34
Total number of providers in the sample	**120**	**-**	**38**	**-**

*Other reasons not specified by respondents

INFLUENCING FACTORS FOR PROVIDER DECISIONS ABOUT FP METHODS TO PRESCRIBE

AGE REQUIREMENTS

Table 18 shows the provider's perceptions on whether a minimum and maximum age influences their decision on what method to prescribe. The stated average minimum and maximum ages to dispense a method are presented in Table 19. Findings were similar among all provider categories, and show that for each method, some providers consider that there is a minimum and maximum age they would recommend to provide a method. The main methods for which most of the providers believed there is a minimum and maximum age limit included: injectables, OCPs, IUCDs, and female sterilization.

As shown in Table 19, there were a lot of similarities in the mean maximum ages providers recommended for providing most methods, but variations existed in the minimum age. The mean minimum age that providers would prescribe OCPs was 15.4 among nurses/health officers and 15.9 among HEWs, and a mean maximum age of 44.2 among nurses/health officers and 42.8 among HEWs. The mean minimum age for dispensing condoms was 15.1 among nurses/health officers, but 16.2 among HEWs. The mean minimum and maximum ages for dispensing injectables was similar among nurses/health officers and HEWs, but there was a clear variation in the minimum age for providing implants—the mean age among nurses/health officers was 16.6, but 18.6 among HEWs. Other details are provided in Table 18.

TABLE 18: MINIMUM AND MAXIMUM AGE PROVIDERS WILL SUPPLY METHODS BY PROVIDER TYPE

Method	Nurse/Health Officer				HEW			
	Believe there is a minimum age to prescribe a method		Believe there is a maximum age to prescribe a method		Believe there is a minimum age to prescribe a method		Believe there is a maximum age to prescribe a method	
	(n)	**(%)**	**(n)**	**(%)**	**(n)**	**(%)**	**(n)**	**(%)**
OCP	59	50	62	53	35	54	41	63
Condom	37	31	20	17	27	42	20	31
IUCD	61	52	61	52	31	48	33	51
Injectable	68	58	67	57	42	65	45	69
Implant	59	50	63	53	34	52	35	54
Female sterilization	70	59	58	49	39	60	33	51
Vasectomy	67	57	45	38	36	55	26	40
Emergency contraception	31	26	38	32	22	34	27	42
Number of providers	**118**	**-**	**118**	**-**	**65**	**-**	**65**	**-**

TABLE 19: MEAN OF MINIMUM AND MAXIMUM CLIENT AGE FOR PRESCRIBING A METHOD BY PROVIDER TYPE

	Nurse/Health Officer	HEW	Nurse/Health Officer	HEW
	Mean of minimum age		Mean of maximum age	
OCP	15.4	15.9	44.2	42.8
Condom	15.1	16.2	45.2	48.1
IUCD	18.9	20.5	45.4	44.8
Injectable	16.9	16.7	45.1	44.7
Implant	16.6	18.6	45.7	44.4
Female sterilization	28.1	25.4	45.9	45.4
Vasectomy	30.0	28.2	49.8	46.2
Emergency contraception	15.4	16.1	45.3	45.6
Number of providers in the sample	**118**	**63**	**118**	**63**

MARITAL STATUS, NON-MENSTRUATING WOMEN AND PARTNER CONSENT

With the exception of female sterilization, most providers seemed open to prescribing FP methods to unmarried women. With regard to implants, however, while 76% of the providers would insert to an unmarried woman, about half of HEWs said they would not. For non-menstruating women, except for condoms and pills, only a few providers said they would deliver IUCDs, injectables, and implants to non-menstruating women. Regarding partner consent, the main methods for which the providers would require partner consent included: sterilization, implants, and injectables (mostly by HEWs in health posts).

TABLE 20: PERCENT OF PROVIDERS WHO WOULD PRESCRIBE THE FP METHODS UNDER SPECIFIC CONDITIONS BY PROVIDER TYPE

	Nurse/Health Officer		HEW		Nurse/Health Officer		HEW		Nurse/Health Officer		HEW	
	Providers who would prescribe method to an unmarried woman				Providers who would provide methods to a non-menstruating woman				Providers who would require husband or partner's consent before providing method			
	(n)	(%)	(n)	(%)	(n)	(%)	(n)	(%)	(n)	(%)	(n)	(%)
OCP	102	86	57	88	78	66	45	69	24	20	23	35
Condom	111	94	59	91	96	81	43	66	38	32	27	41
IUCD	63	53	27	41	27	23	5	8	55	47	36	55
Injectable	89	75	46	71	25	21	4	6	29	25	30	46
Implant	90	76	36	55	30	25	2	3	47	40	38	59
Female sterilization	17	14	14	21	30	25	5	8	99	84	49	75
Emergency contraceptive pill	97	82	42	65	58	49	18	28	20	17	18	28
Number of providers	**118**	**-**	**65**	**-**	**118**	**-**	**65**	**-**	**118**	**-**	**65**	**-**

PROVIDER METHOD RECOMMENDATIONS FOR SPACING AND STOPPING BIRTHS AND FOR CLIENTS WITH SEXUALLY TRANSMITTED INFECTIONS (STIS) AND REPRODUCTIVE TRACT INFECTIONS (RTIS)

Table 21 shows the FP methods that providers would recommend to clients who want to space births, stop child birth and the methods they would not prescribe to clients with a sexually transmitted infections (STI) or reproductive tract infections (RTI). Among the providers at hospitals and health centers, the main methods they would recommend to clients who want to space births were: Implanon (96%), the IUCD (78%), Jadelle (77%), the injectable (65%), and OCPs (61%). This pattern was also similar among health extension workers, although the injectable was the main recommendation. For clients who want to stop childbirth, 83% of the providers at hospitals and health centers, and 80% of the HEWs said they would recommend female

sterilization. The IUCD was the main method that most providers stated they would not recommend for clients who have an STI or RTI.

TABLE 21: PROVIDER RECOMMENDATIONS REGARDING THE USE OF VARIOUS FP METHODS BY TYPE OF PROVIDER

	Nurse/ Health Officer		HEW		Nurse/ Health Officer		HEW		Nurse/ Health Officer		HEW	
	Provider recommended method to clients who want to space births				Provider recommended method to clients who want to stop child birth				Methods not recommend to clients with an STI or RTI infection			
	(n)	**(%)**	**(n)**	**(%)**	**(n)**	**(%)**	**(n)**	**(%)**	**(n)**	**(%)**	**(n)**	**(%)**
OCP	69	61	40	68	14	12	13	21	4	4	5	15
Injectable	73	65	47	80	15	13	18	30	4	4	6	18
IUCD	88	78	39	66	62	54	22	37	95	94	26	77
Implanon	108	96	46	78	39	34	21	35	5	5	6	18
Jadelle	87	77	28	48	37	32	12	20	3	3	2	6
Norplant	3	3	5	9	0	0	0	0	2	2	1	3
Trust	19	17	1	2	3	3	0	0	2	2	0	0
Implant (unspecified)	0	0	1	2	1	1	1	2	1	1	0	0
Condom	60	53	27	46	16	14	7	12	2	2	9	27
Emergency contraception	28	25	8	14	7	6	3	5	3	3	0	0
Female sterilization	0	0	0	0	90	83	52	80	0	0	0	0
Number of providers interviewed	**118**	**-**	**65**	**-**	**114**	**-**	**60**	**-**	**101**	**-**	**34**	**-**

PROVIDER STRATEGIES FOR SUPPLYING HORMONAL CONTRACEPTIVES

Ninety-one percent of the nurses and health officers working in hospitals and health centers would conduct a pregnancy test to decide whether or not to supply a hormonal method to a new client who is not having her menses. In health posts, 66% of the providers stated the same. One quarter of the HEWs (25%) would ask the client to come back at her next menses, compared with 13% among the nurses and health officers. Also, 31% of the HEWs and 17% of the nurses/health officers would supply the method. Other results are shown in Table 22.

TABLE 22: STRATEGIES TO SCREEN FOR PREGNANCY IN ORDER TO DELIVER HORMONAL METHODS TO CLIENTS NOT MENSTRUATING AT TIME OF VISIT BY PROVIDER TYPE

Criteria for screening	Nurse/ Health Officer		HEW	
	(n)	(%)	(n)	(%)
Do pregnancy test	107	91	43	66
Tell client to come back	15	13	10	25
Use check list to rule out pregnancy	19	16	3	22
Supply hormonal method	20	17	11	31
Supply hormonal method and condom	12	10	3	15
Number of providers	**118**	**-**	**65**	**-**

FP SERVICE DELIVERY ENVIRONMENT

Overall, most of the FP consultations observed were conducted in a private area. In 77% of observations with new clients in health posts and 74% in hospitals and health centers, providers obtained the biographical information of the clients. In observations of new clients receiving FP services in hospitals and health centers, 73% were asked what their reproductive goals were, but in health posts, 62% of the clients were asked. However, as seen in Table 23, providers did not generally inform their clients that the discussions they held were going to be kept confidential. Additionally, while in 65% of the new client's observation and in 56% of the observations of repeat clients the providers discussed the needs of their clients in a sympathetic manner, this was generally less likely in health posts. This probably results from the fact that most of the HEWs are known to their clients from their community interactions.

TABLE 23: PROPORTION OF OBSERVATIONS WHERE THE PROVIDER CREATED A POSITIVE ENVIRONMENT BY FACILITY TYPE

	Hospital/Health Center				Health Post			
	New client		Repeat client		New client		Repeat client	
	(n)	(%)	(n)	(%)	(n)	(%)	(n)	(%)
Consultations conducted in private area	60	81	147	78	11	84	51	70
Clients biographic information obtained by the provider	55	74	119	64	10	77	25	35
Clients were informed that discussions are confidential	15	20	29	16	3	23	15	21
Clients reproductive goal was asked for by the provider	54	73	116	63	8	62	27	37
Provider discussed client needs and concerns in sympathetic manner	48	65	104	56	4	31	26	36
Number of clients observed receiving services	74	-	185	-	13	-	72	-

INFORMED CHOICE COUNSELING

Data on provider and client interactions during counseling were only analyzed for interactions where the clients were new FP users, restarting clients, or method switching clients. Results show that method preference was asked in 95% of the observations of new clients and 85% of the method switching/restart clients in hospitals and health centers; and in 85% of the observations of new clients and 64% of the method switching/restart clients in health posts. Results also show that in 96% of the new clients, and in 87% of the method switching/restart client's observations in hospitals and health centers, clients spontaneously mentioned their method of choice. In health posts, spontaneous mention of the method of choice was observed in 92% of the new clients, and in 58% of the method switching/restart clients. . Results also show that providers in hospitals and health centers helped their client to choose a method in 85% observations of new clients and in 76% observations of method switching/restart clients. In health posts however, providers were more likely to help new clients to choose a method (92%) than in repeat clients (54%).

During data collection, the interviewers noted the FP methods that the providers comprehensively counseled clients on. Again, these data were only analyzed for interactions where the clients were new FP users, restarting clients, or method switching clients. The results are summarized in Table 24. Generally, the providers were less likely to conduct comprehensive counseling, particularly for implants, condoms and sterilization. Most of the providers in hospitals and health centers tended to give comprehensive counseling to clients on injectables, pills and IUCDs, but not on condoms, implants and sterilization. Only 22% of the new clients in hospitals and health centers were counseled on implants and on sterilization. Similarly, only 24% of the repeat/restart clients in hospitals and health centers, and 25% were counseled on implants and sterilization respectively. Overall, providers were least likely to counsel clients on condoms. Other results can be seen in Table 24.

TABLE 24: RECEIPT OF INFORMED CHOICE COUNSELING AMONG NEW, RESTARTING, AND SWITCHING CLIENTS BY FACILITY TYPE

	Hospital/ Health center				Health post			
	New client		**Switching/ restart client**		**New client**		**Switching/ restart client**	
	(n)	**(%)**	**(n)**	**(%)**	**(n)**	**(%)**	**(n)**	**(%)**
Method-specific counseling and screening items observed being given to new, restarting, and switching clients								
Provider asked if client had a method preference	70	95	158	85	11	85	46	64
Client spontaneously mentioned a method preference	71	96	161	87	12	92	42	58
Provider asked about the client's current use of FP methods	56	76	154	83	6	46	44	61
Provider asked about client's past use of FP methods	53	72	130	70	8	62	41	57
Provider helped the client choose a method	63	85	140	76	12	92	39	54
Methods that the provider gave comprehensive counseling about to the clients								
Pills	44	59	89	48	7	54	19	26
Injectable	53	72	109	59	9	69	33	46
Implant	16	22	44	24	0	0	9	13
Condom	15	20	42	23	0	0	9	13
IUCD	38	51	102	55	3	23	11	15
Sterilization	16	22	47	25	2	15	9	13
Number of clients observed receiving services	**74**	**-**	**185**	**-**	**13**	**-**	**72**	**-**

CLIENT SCREENING AND METHOD-SPECIFIC COUNSELING

In the hospitals and health centers, a total of 152 new, restart or method switching clients were observed, and another 29 observations were conducted in the health posts. Among the clients observed receiving FP services in hospitals and health centers, in 88% of the observations providers screened clients for medical contraindications, explained how to use the method in 76% of the observations, explained method effectiveness in 64% of the observations and screened for medical contraindications in 61% of the observations. However, in only 32% of the observations were the clients given an explanation of what to do if they experienced problems with their method. In health posts, clients were screened for pregnancy in 76% of the observations, were told how to use the selected method in 65% of the observations, and explained the effectiveness of the method in 55% of the observations. In the majority of client-provider interactions observed at health posts, providers did not explain the likely side effects, and just over half of the observations witnessed included a screening for medical contraindication.

TABLE 25: PROPORTION OF OBSERVATIONS WHERE NEW, RESTARTING, AND SWITCHING CLIENTS RECEIVED METHOD-SPECIFIC COUNSELING AND WERE PROPERLY SCREENED BEFORE STARTING THE METHOD

Characteristic	Total		Hospital/health center		Health post	
	(n)	(%)	(n)	(%)	(n)	(%)
Provider screens clients for medical contraindications	108	59	93	61	15	52
Provider screens client for pregnancy	155	86	133	88	22	76
Provider explains effectiveness of method selected	113	63	97	64	16	55
Provider explains how to use method	134	74	115	76	19	65
Provider explains side effects and ensure client understands	97	53	86	57	11	38
Provider explains what to do if client has problem	74	41	65	32	9	3
Number of new, restarting and switching clients observed receiving method specific counseling	**181**	**-**	**152**	**-**	**29**	**n/a**

QUALITY OF IMPLANT SERVICE DELIVERY

In Table 26, results related to observation of the interactions between the providers and their clients during counseling and insertion of implants are presented. The study does not describe the results for the observation of implant insertion at health posts as only three clients were observed receiving implants at the health posts. A total of 54 clients were observed at the hospitals and health centers receiving implants. In the majority of observations, the providers performed most of the recommended steps during implants insertion as shown in Table 26, however, in less than 50% of the observations the following steps were not performed: the provider washing his/her hands prior to insertion (31%); use of the checklist to screen the client for medical eligibility and/or pregnancy (39%); and provider telling the client of the warning signs of an infection (46%).

TABLE 26: ASPECTS OF QUALITY AND ASEPTIC IMPLANT SERVICE PROVISION AMONG OBSERVATIONS WHERE IMPLANTS WERE DELIVERED

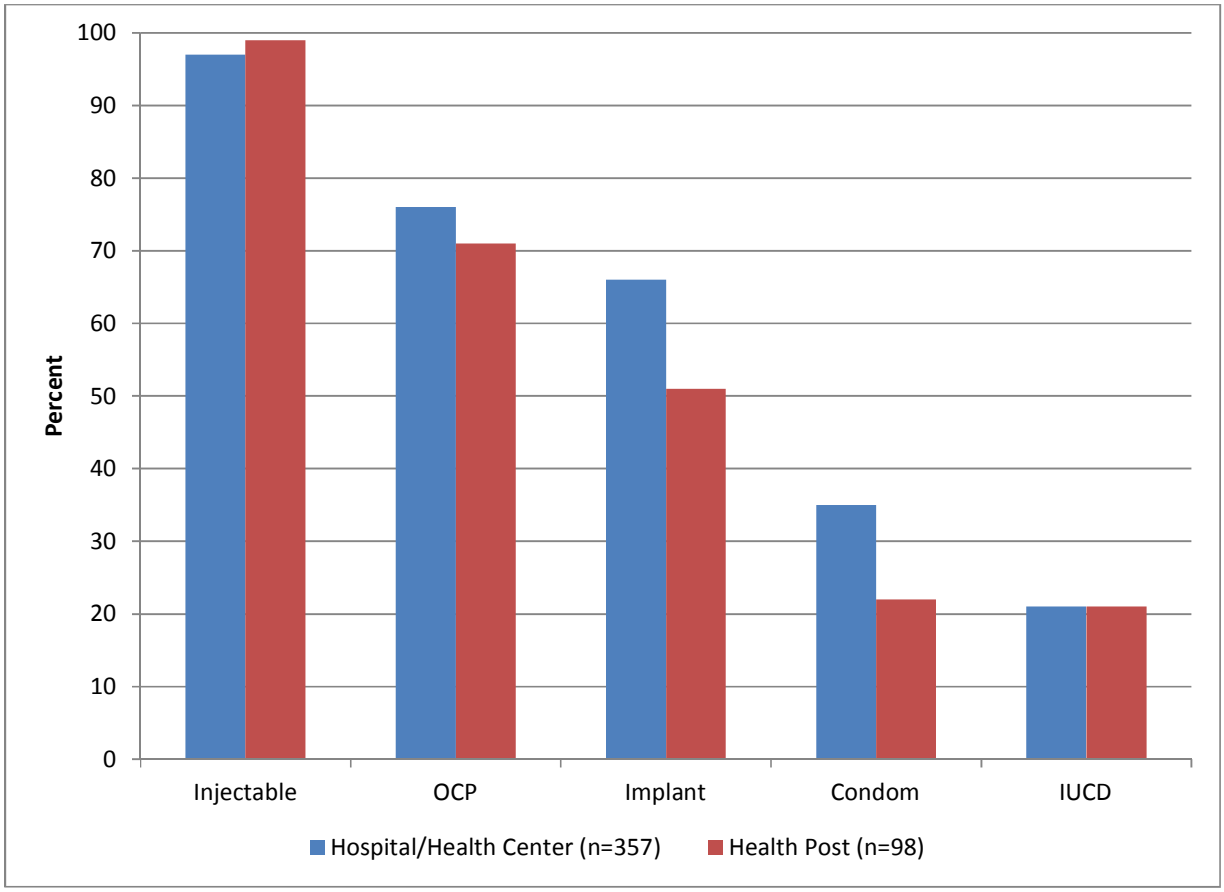
	Hospital/ Health Center		Health Post	
	(n)	(%)	(n)	(%)
Quality Service Provision				
Provider gave method-specific counseling including side effects	42	78	3	100
Provider used a checklist to screen for medical eligibility and/or pregnancy	20	39	0	0
Provider answered any additional questions of the clients	42	78	2	66
Provider reassured the client during insertion process	43	80	3	100
Provider told client how to take care of insertion site	46	85	2	67
Provider told client warning signs of infection	25	46	2	67
Provider told the client when to return for follow up care	34	62	2	67
Provider gave client reminder card for implant removal	51	94	2	67
Provider told client where to go for removal	46	85	2	67
Provider recorded procedure in log book	46	85	2	67
Aseptic Implant Service Provision				
Provider inserted the implant in a clean and private room	42	82	2	66
Provider washed his/her hands before beginning the procedure.	17	31	2	67
Provider checked the expiry date on the implant package	30	55	2	67
Provider opened the implant package immediately before inserting the implant	51	94	2	67
Provider inserts the implant with aseptic procedure	48	88	2	67
Provider properly disposes of the trocar	47	87	2	67
Provider wraps the client arm.	48	88	2	67
Number of providers observations of implant insertion	**54**	**-**	**3**	**-**

CLIENT'S KNOWLEDGE AND BELIEFS ABOUT FP METHODS

AWARENESS ABOUT FP METHODS

Injectable contraceptives were by far the most known FP method—97% of the hospitals and health centers clients, and 99% of the health posts clients were aware of injectables. Most clients were also aware of OCPs. In terms of implants, 66% of hospital and health center clients, and 51% of the health post clients were aware if implants. IUCD was generally less known by the clients, with only 21% of the clients in both hospitals and health centers and health posts reporting awareness of IUCD.

FIGURE 13: PERCENT OF CLIENTS WHO ARE AWARE OF THE FP METHODS BY FACILITY TYPE



PERCEPTIONS OF COMMUNITY AWARENESS AND BELIEFS ABOUT IUCD AND IMPLANTS

The communities perceptions about IUCDs and implants presented in this section are based on the impressions of the respondents.

FP CLIENTS PERCEPTION OF COMMUNITY AWARENESS AND INTEREST IN IUCD

Results show that awareness about IUCD is low among women in the communities. Only 28% of the hospital and health center clients and 24% clients in health posts believe that most women in their communities know about IUCDs. When asked if they believed that most women in their communities would be interested in using IUCD, only 21% hospital and health center clients said they believed most women in their communities would be interested in using IUCDs.

Among the clients who believed women in their communities would be interested in IUCDs, the two main reasons for this perception were: the long-term effectiveness of IUCDs (62% in hospital and health center clients, and 80% health post clients); and the effectiveness of IUCDs in preventing

pregnancy (26% in hospital and health center clients, and 20% or 3 women out of 15 in health post clients).

Of clients who were familiar with IUCDs, 22% of the hospital and health center clients and 25% of the health post clients had heard negative things about IUCDs. Almost half (49%) of the hospitals and health center clients, and 30% of the health posts clients who reported hearing negative things about IUCDs cited medical side effects. The second common response about the negative things heard about IUCD stated by 22% of the hospitals and health center clients, and by 40% of the health posts clients, related to fear of insertion procedure. Another 19% of the hospitals and health centers clients said they had heard that IUCDs cause infertility.

TABLE 27: CLIENT PERCEPTION OF COMMUNITY BELIEFS ABOUT IUCDS

Women's Beliefs	Hospital/ Health Center		Health Post	
	(n)	(%)	(n)	(%)
Perception of awareness about IUCD in the community				
Percent of FP clients who believe that most women in community know about IUCDs	99	28	24	24
Number of exit FP clients	**356**	**-**	**98**	**-**
Perception of interest in IUCD in the community				
Percent clients who believed that most women in community would be interested in using IUCDs	55	22	15	31
Number of exit FP clients who believed that most women in their community know about IUCD	**254**	**-**	**49**	**-**
Reasons for the perception of interest in IUCDs				
Effective at preventing pregnancy	14	26	3	20
Effective for long time	34	62	12	80
Don't have to remember anything to make it work	1	2	0	0
Don't have to return to the clinic	1	2	0	0
Other	3	6	0	0
Don't know	2	4	0	0
Number of FP clients who believed that most women in their community would be interested in using IUCDs	**55**	**-**	**15**	**-**
Reasons for the perception that most women would not be interested in IUCDs				
Medical side effects	13	21	7	58
Husband/partner does not like method	2	3	0	0
Fear of infertility	3	5	1	8
Other	19	31	1	8
Don't know	25	40	3	25
Number of FP clients believed that most women in their community would not be interested in using IUCDs	**62**	**-**	**12**	**-**
Whether women have heard negative things about the IUCD*				
Percent of women who have heard negative things about IUCDs	37	22	10	25
Number of women who are aware of IUCD	**125**	**-**	**16**	**-**
Negative things clients have heard about IUCDs				
IUCDs cause infertility	7	19	1	10
IUCDs cause medical side effects	18	49	3	30
Fear of insertion	8	22	4	40
IUCD expulsion	5	14	0	0
Other	8	22	2	20
Number of women who have heard negative things about IUCD	**37**	**-**	**10**	**-**

*Excludes women who are not familiar with IUCDs

FP CLIENTS PERCEPTION OF COMMUNITY AWARENESS AND INTEREST IN IMPLANTS

Results show the percentage of hospital and health center clients and health post clients who believed that women in their communities were aware of implants was similar (58 and 59% respectively). Similarly, the results on client's perception of interest in implants in their communities were also comparable between hospital and health center and health post clients (49% and 46% respectively).

Among the clients who perceived that most women in their communities would be interested in implants the main reasons cited were: their long-term effectiveness (52% in hospitals and health centers clients, and 67% in health posts clients), and effectiveness in preventing pregnancy (25% in hospitals and health centers clients, and 24% in health posts clients). For those who said most women in their communities would not be interested in implants, medical side effects were mostly cited (42% in hospitals and health centers clients and 32% in health posts clients).

Findings also show that 35% of the hospital and health center clients and 24% of the health posts clients had heard negative things about implants. The main negative thing heard by most clients was side effects. Detailed results can be seen in Table 28.

TABLE 28: CLIENT PERCEPTION OF COMMUNITY BELIEFS ABOUT IMPLANTS

	Hospital/Health Center		Health Posts	
	(n)	(%)	(n)	(%)
Perception of awareness about implants in the community				
Percent of clients who believe that most women in community know about implants	207	58	53	59
Number of exit FP clients	**356**	**-**	**98**	**-**
Perception of interest in implants in the community				
Percent of clients who believe that most women in community would be interested in using implants	142	49	33	46
Number of exit FP clients who believed that most women in their community know about implants	**289**	**-**	**71**	**-**
Reasons for the perception of interest in implants				
Effective in preventing pregnancy	36	25	8	24
Effective for long time	74	52	22	67
Don't have to remember anything to make it work	3	2	0	0
Don't have to return to the clinic	6	4	2	6
Other	7	5	0	0
Don't know	16	11	1	17
Number of exit FP clients	**142**	**-**	**33**	**-**
Reasons for the perception that most women would not be interested in implants				
Medical side effects	23	42	7	32
Husband/partner does not like method	1	2	0	0
Fear of infertility	5	9	0	0
Other	14	25	7	32
Don't know	12	22	8	36
Number of clients who believed that most women would not be interested in implants	**55**	**-**	**22**	**-**
Negative things women have heard about the implant*				
Percent of client who have heard negative things about implant	102	35	17	24
Number of clients who were aware of implants	**289**	**-**	**71**	**-**
Negative things heard about implants				
Implants cause infertility	20	20	0	0
Implants cause medical side effects	84	82	16	94
Fear of insertion	9	9	0	0
Other	2	5	0	0
Number of women who heard negative things about implants	**102**	**-**	**17**	**-**

*excludes clients who are not familiar with implants

DISCUSSION

This study shows that the majority of FP providers at the health centers and hospitals studied are nurses or health officers, and that HEWs are playing a significant role in FP service delivery at the health post level. Virtually all providers are female, and they have mostly been involved in dispensing of short acting methods, which is indicative of the training they had received. About half of the providers at hospitals and health posts are trained in IUCD insertion and removal, and 60% are also trained in implant insertion and removal. At health posts, about 40% of the providers interviewed had been trained in Implanon insertion. A major aspect for the success of the IUCD and Implanon initiative thus calls for further expansion of the training of providers. However, while training providers will enable expansion of the method mix, efforts should also focus on examining workload concerns of HEWs. Even if the method used to measure workload was crude, it still establishes the inherent perceptions of the providers about their workload. About two thirds of the hospital and health center providers stated that their workload was manageable, but a significant number of HEWs believed their workload was too much. This perception from HEWs cannot however be confirmed unless an appropriate study using the correct methodology is conducted to asses health providers workload. Possible areas of further investigation of why HEWs perceive heavy workload could examine if HEWs are involved in other community activities beyond delivery of health services, and also the ability of the HEWs to organize and effectively plan their work. Thus, without a more in-depth study on provider's workload it is not possible to conclude from these findings that the workload is excessive for HEWs. However, strategies to improve efficiency should be considered.

During the planning phase for the IUCD revitalization, discussions among partners on the training strategy centered on whether to conduct refresher training or comprehensive training for long acting methods. Findings from this study indicate that a more in-depth training is necessary given that the majority of providers have not received any training on these methods. Findings also show that there is a positive interest among providers to deliver implants and IUCDs, but the lack of training was their limiting factor. This finding seems to contradict anecdotal information suggesting that provider bias is one of the main factors for low provision of IUCD. However, a qualitative study using focus groups and/or in-depth interviews with providers would have probably yielded better understanding of provider biases than in a quantitative study such as this one.

The government effort to improve access to health services in the studied sites is confirmed by the findings of this situation analysis. Most of the health facilities were within the walking distance of FP clients, which suggests that the FP users lived within the vicinity of the health facilities and used

FP services provided in the health facilities within their reach. FP clients also found the operating hours of the health facilities to be convenient. Furthermore, the majority of health facilities offered FP services at least five days a week. Understanding of FP referrals from health posts to health centers and hospitals is however necessary, especially the services referred for and the completion of such referrals. This will help to understand the capacity of HEWs to counsel and refer clients for services not provided in health posts, and will also inform capacity building plans for HEWs on referrals.

FP services appear to be reaching poor women, including those with limited education. Nearly three in four of the exit clients either had no formal education, or only some primary education, and about 60% either could not read in their local languages or read with difficulty, and over 80% walked to the health facility. However, nearly all FP clients were married raising the question of whether unmarried women have adequate access to FP services.

With regard to basic infrastructure for FP service delivery, findings suggest the need to improve availability of water in the FP/MCH units of the health facilities, and more so in health posts where the majority of the basic infrastructure items were lacking. However, the conditions of the medical examination areas were generally good in all facilities. Findings also confirm that over 70% of the hospitals and health centers had the necessary equipment to deliver FP services, which implies that with training and provision of products and consumables, the hospitals and health centers are materially capable of providing more FP services, including surgical methods. As for health posts, the available equipment seems consistent with their level of service provision, which focuses on short acting methods and Implanon insertion.

Availability of FP methods, particularly in hospitals and health centers was impressive. The average number of methods available in hospitals and health centers was 4.4, with the majority of them having over four method choices in stock. In health posts, the average number of methods available was 2.7—mostly accounted for by the hormonal methods and Implanon. However, while over 75% of the hospitals and health centers had the necessary consumables for FP service delivery, health posts generally lacked antiseptic solutions and anesthetic medication.

Overall, service delivery was found to be good; however, a few areas for improvement are recommended. There is evidence that supplying 13 cycles of pills to a woman during an initial visit significantly increases the likelihood of continuing to use pills 15 months after the initial

prescription[16]. As is characteristic of most developing countries, the largest proportion of the population is rural and proximity to health facilities is limited for the majority. Similarly, health seeking behaviors are influenced by many other factors. Thus, even if it is not always feasible due to resource limitations and other associated factors, every visit to the health facility by women needing OCPs should be seen as an opportunity to dispense several months' supply of pills. This recommendation should be considered for inclusion in FP Policy guidelines, and if programmatically feasible, it should be adhered to. Based on the findings from this study, the majority of providers already tend to prescribe 3-4 OCP cycles per visit.

A need to improve counseling of clients was identified. While providers seem to address the main items followed in method-specific counseling particularly for new clients, such as obtaining biographic information, allowing the client to spontaneously state their method of choice and helping the client to choose a method, we found that comprehensive counseling was not adequately provided on FP methods. Specifically, most of the providers in hospitals and health centers tended to focus their comprehensive counseling on methods to clients who obtained injectables, pills and IUCDs, there was a low tendency to also counsel on condoms, implants and sterilization. Explanation of side effects and providing clients with advice on what to do if they experienced problems with their method are specific areas for improving counseling.

To successfully scale up IUCD services, the situation analysis findings also indicate an urgent need to increase awareness in the target population. Less than one third of the clients thought women in their communities knew about IUCD. While there is a common belief that there are many negative beliefs about IUCD, only 22% of the exit clients who knew of the IUCD had heard any negative things about IUCD mostly related to side effects. The low awareness about IUCD thus offers the opportunity to increase IEC messaging that also addresses commonly known negative things that have been said about IUCDs in other countries.

The findings from this study also showed that there are provider biases in prescribing FP methods, particularly among HEWs. In hospitals and health centers, marital status does not seem to influence provider prescription of FP methods (excluding sterilization), but it does among the HEWs. It is evident though, that age is a major factor in the provider prescription of FP methods. Thus, issues related to provider biases in the prescription of methods should be addressed in the training.

[16] Foster DG, et al. Number of oral contraceptive pill packages dispensed, method continuation, and costs. *Obstet Gynecol*. November 2006;108:1107–14.

STUDY LIMITATIONS

The Situation Analysis methodology is designed to provide a snapshot of FP services on a single day at each facility. Because a facility is only visited for one day, the number of clients receiving less popular methods is limited. In this instance, the vast majority of clients received DMPA injections and very few clients were observed receiving implant or IUCD insertions. Additionally, as the majority of clients are not new to FP use, observing and interviewing new clients is not as likely with only one day of data collection at the facility.

The study focused only on women who came for FP services, thus the FP practices or intentions of women who came for non-FP services were not captured. Also, HEWs, while based at health posts, spend a significant portion of their time doing community outreach service provision and, as a result, many of the non-clinic clients of HEWs were likely not represented in the sample.

The generalizability of the findings is limited given that the data are based on a convenience sample. For example, in each woreda, only accessible facilities were surveyed, so FP service provision and circumstances of the facilities in remote and difficult to reach areas may not be represented by these findings. Also, the woredas selected for inclusion in the study may be performing at a different level than other woredas due to their inclusion in the IUCD scale-up initiative.

CONCLUSION

Based on these findings, most of the health facilities surveyed have the capacity for provision of short acting methods, and while the basic infrastructure for IUCD insertion at the hospitals and health centers, and implant insertion at all levels exists, training both existing and new providers is necessary to expand coverage. Provider interest to conduct IUCD and implants services is also evident. While this study was not intended to generate conclusive evidence of the impact of the FP interventions of the government, the findings suggest that the government strategies to improve access to FP services have paid off given that clients receiving services in the studied sites are able to access facilities within less than an hour walk away, and operating hours are convenient. One of the main infrastructural areas for improvement is increasing availability of water in the FP/MCH units.

This study has also established that possible barriers to long acting methods uptake mostly include low awareness, particularly of IUCDs, and provider perceptions of restrictions related to client's age parity, marital status, menstruation, and husband consent. Additionally, FP guidelines do not discuss any of these possible limitations and how they can be addressed, calling for possible review

or supplementation of the guidelines. Furthermore, HEWs are reporting heavy workload, which means that balancing of the workload, or adding more HEWs to health posts, could be a key consideration.

Overall, the results show that access to FP services is good considering that the services are now within minutes of walking distance to the clients. Training lower-level cadres of providers such as HEWs to provide FP services can be successful model of task sharing that should be considered in other countries. With the continued commitment and support of the Government of Ethiopia, and with donor support focused on sustainable approaches, access to FP services will continue to increase and countries will continue to look towards Ethiopia as a model to follow.

APPENDIX 1. WOREDAS INVOLVED IN IUCD REVITALIZATION

Region	Woreda/ Sub cities	Population (2007 Census)[17]
Addis Ababa	Arada	211,501
	Yeka	346,664
	Lideta	201,713
	Gulele	267,624
	Kirkos	221,234
	Addis Ketema	255,372
	Akaki Kality	181,270
	Kolfe Keraniyo	428,895
	Bole	308,995
	Nefasilk Lafto	316,283
Amhara	Woreta Town	21,222
	Metema Town	94,592
	D/Tabor Town	50,848
	Woldya Town	46,139
	Efrata Gidim	15,319
	Gondar Town	TBD
	Injebara Town	21,065
	Bechana	TBD
	D/work	TBD
	Dejen	102,359
	Dambacha	129,260
	Lagambo	165,026
	Legehida	67,138
	Wegedi	135,240
	Mekdela	5,115
	Menjar	128,879
	Merhabete	13,113
	Baherdar Town	155,428
	Dangala Town	24,827
	Dessie Town Adm	151,174
Dire-Dawa	Dire-Dawa	233,224
Oromiya	Nejo and Nejo Zuria	130,909
	Gida Ayana	10,526
	Dembidelo Town and Seyo	TBD
	Tiyo	86,761
	Shashemene	100,454
	Dodola	193,812
	Kuyyu	TBD
	Tena	6,252
	Merti	90,408
	Diksis	72,301
	Sude	147,764
	Ginbichu	TBD

[17] 2007 Ethiopia Census. Data available from: http://www.csa.gov.et/

	Liban	TBD
	Yubdo	38,858
	Genji	59,793
	Homa	24,557
	Gudeyabila	TBD
	Manasibu	TBD
	Ada'a	15,940
	Laloasabi	TBD
	Sandafa	TBD
	Mojo Town	29,547
	Adama Town	220,212
	Zeway Town	43,660
	Inchini Town	7,307
	Holeta Town	25,593
	Bishoftu Town	99,928
	Jima Town	TBD
Somali	Jijiga	277,560
SNNP	Wondo Genet	155,715
	Aleta Wondo	22,093
	Dara	155,265
	Humbo	125,441
	Dilla Town	59,150
	Hossaena	69,995
	Kacha Bira	113,687
	Mareka	126,022
	Hawasa Zuria	TBD
	Wolkite Town	TBD
	Endeber Town	TBD
	Werabe Town	9,480
	Kella Town	3,519
	Sheko	49,914
	Decha	128,887
	Ginbo	TBD
	Kochore	3,301
	Gadabi	TBD
	Gorche	105,472
	Chuko	18,467
	Dale	242,658
	Tocha	102,848
	Halaba	TBD
	Wonago	8,471
	Misrak Baewocho	142,823
Tigray	Adwa Town	40,500
	Adigrat Town	57,588
	Wukro Town	30,210
	Maichew Town	23,419
	Alamata Town	85,403
	Mekelle Town	215,914

	Axum Town	44,647
	Shire Town	47,284
	Kilte Awelaelo	99,708
Total	**94**	

APPENDIX 2: WOREDAS VISITED

Team Number	Region	Woreda
1	Addis Ababa	Arada
	Addis Ababa	Akaki Kality
	Addis Ababa	Lideta
2	Amhara	Wegedi
	Amhara	Injebara Town
	Amhara	Merhabete
3	Amhara	Woldya Town
	Amhara	Lagambo
	Amhara	Mekdela
4	Oromiya	Yubdo
	Oromiya	Nejo Zuria
	Oromiya	Manasibu
5	Oromiya	Tiyo
	Oromiya	Sude
	Oromiya	Tena
	Oromiya	Adama Town
6	Oromiya	Kuyu
	Oromiya	Sandafa
	Diredawa	Dire dawa
7	SNNP	Chuko
	SNNP	Hawasa Zuria
	SNNP	Gadabi
	SNNP	Aleta Wondo
8	SNNP	Werabe Town
	SNNP	Sheko
	SNNP	Humbo
	SNNP	Wolkite Town
9	Tigray	Maichew Town
	Tigray	Wukro Town
	Tigray	Adwa Town

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