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Ministry of Health

THE INTRA-UTERINE CONTRACEPTIVE DEVICE REVITALIZATION INITIATIVE

March, 2014

*Results and Lessons
from the Initial
Phase.*

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ACRONYMS

CPR	Contraceptive Prevalence Rate
ECPs	Emergency Contraceptive Pills
FMOH	Federal Ministry of Health
FP	Family Planning
HEP	Health Extension Program
HEW	Health Extension Workers
IEC	Information, Education and Communication
IFHP	Integrated Family Health Program
IUCD	Intra-Uterine Contraceptive Device
LAFP	Long-Acting Family Planning
MDG	Millennium Development Goals
MSIE	Marie Stopes International Ethiopia
OCPs	Oral Contraceptive Pills
RHB	Regional Health Bureau
SNNPR	Southern Nations Nationalities' and Peoples' Region
TFR	Total Fertility Rate

EXECUTIVE SUMMARY

This report describes the findings from a midterm evaluation of the Intra-uterine Contraceptive Device (IUCD) revitalization initiative conducted by the Federal Ministry of Health (FMOH) and FHI 360. FHI 360 provided financial and technical support to the FMOH to conduct a process evaluation of the initial phase of the IUCD initiative with two main purposes: 1) to determine if women are being targeted effectively by IUCD information campaigns and materials, and 2) to consolidate lessons learned from the initial implementation in 116 woredas to guide the national expansion.

The mid-term evaluation was conducted in Amhara, Tigray, Southern Nations Nationalities People (SNNP), Oromia, Addis Ababa and Dire Dawa. The lessons learned from this initial phase provide guidance to the FMOH and implementing partners in developing strategies to improve family planning (FP) services and increase IUCD uptake in health facilities. The results contained in this report also support making of informed programmatic decisions during scale-up.

Data were collected using quantitative and qualitative methods. Quantitative data collectors conducted facility inventories, collected service statistics, and administered provider and female client interviews at selected hospitals and health centers. Additionally, in-depth interviews were conducted with HEWs and family planning sub process owners/case team members at regional, zonal and woreda health offices.

Results from the facility inventory, service statistics, provider interviews and client interviews are presented in tables stratified by health facility. The evaluation was conducted in a total of 120 health facilities, which included 18 hospitals, 34 urban health centers and 68 rural health centers.

KEY RESULTS

Provider-Related Findings

Provider Training and Facility Readiness to Provide IUCD

Prior to January 2010 when the IUCD initiative was launched, 18 providers from hospitals in the evaluation locations had received training in IUCD services. These providers included clinical nurses, midwives, health officers and general practitioner/specialists. Following the launch of the initiative, 28 providers at hospitals had received IUCD training. At health centers, a total of 29 providers in urban and 56 providers in rural health centers had received IUCD training before January 2010, but 100 providers in urban health centers and 74 in rural health centers received training in IUCD services after January 2010. This results show a substantial increases in the number of providers trained after January 2010: 55% increase in hospitals, over 200% increase in urban health centers and 32% increase in rural health centers.

A total of 221 trained and certified providers in IUCDs services were reported at the surveyed facilities: 18% in hospitals, 46% in urban health centers and 37% in rural health centers. Health professionals who were trained but not certified to provide IUCDs were fewer in

number at 75: 13% in hospitals, 17% in urban health centers and 69% in rural health centers. On the day of the survey, a total of 168 full-time trained and certified providers were physically present across the three facility types: 26 in hospitals, 67 in urban health centers and 75 in rural health centers.

In terms of family planning methods usually provided, facilities had a combination of short-acting and long-term methods. In urban health centers, more than 90% provided all methods except emergency contraceptive pills (ECPs; 79%) and Trust implants (76%). In rural health centers, injectables were reportedly provided in all 68 rural health centers. On the day of the survey, Oral Contraceptive Pills (OCPs), Implanon and condoms were available in over 90% of the health centers, while IUCDs were available in 79%. Related to stock-outs in the last six months, very few facilities were without IUCDs. Only one hospital, one rural health center and one urban health center reported that they had experienced stock outs of that method at some point in the last six months. Pills and implants were more likely to have been out of stock in the last six months, but with the exception of Jadelle and Implanon, most methods did not experience notable stock-outs.

Service Statistics

Service statistics on insertion and removal of long-acting family planning (LAFP) methods were collected for the calendar year 2012 only. A total of 4,202 insertions of the IUCD or implants in the 18 hospitals were determined. The majority of the insertions at hospitals (56%) were for Implanon, and 20% were for the IUCD. In health centers, 31,888 insertions of any LAFP methods were conducted, of which 48% were for Implanon and 25% for IUCD. Removals for LAFP methods were also evident. Records at the hospitals indicate 923 removals of Implants and IUCD at hospitals, the majority being for Implanon (66%) followed by IUCD (12%); and 5,604 removals at health centers, again the majority being for Implanon.

Provider Capacity

Providers were selected to participate in interviews from the three types of facilities (hospitals, health centers and health posts). Thirty providers in hospitals, 67 in urban health centers and 87 in rural health centers were interviewed for a total of 184 providers from the 120 facilities. The majority of providers were female and married. In rural health centers, however, the proportion of male and female providers was almost equal (47% and 53%, respectively), as were married and single providers in both types of health centers. None of the providers interviewed was a medical doctor. In urban health centers, 18% of providers were health officers. The average length of time working as a health service provider was 10 years for hospital-based providers, 9 years for those in urban health centers and 5 years for those working in rural health centers. With regard to average length of time working in their current facility, hospital providers reported 7 years, their urban health center counterparts 5 years, and rural health center providers 3 years.

Providers reported conducting IUCD insertions regularly. Health center providers reported higher average insertions in the past year than hospital providers: 48 by urban and 37 by rural health center providers, which averages to approximately three to four IUCD insertions per month. Overall, there were many more insertions of LAFP methods than removals, and more implant removals than IUCD removals. This is indicative of the timeframe between the revitalization of LAFP methods and the evaluation. The Implanon initiative started towards the end of 2009, while the IUCD initiative was started beginning of 2010. This likely explains why the majority of providers interviewed (58%) reported that they had not performed any IUCD removal.

Providers were also asked about their level of comfort and interest in providing IUCD services. Over two-thirds of providers who were asked about their comfort level reported being very comfortable providing IUCD insertions. Another 12% said they were somewhat comfortable. A similarly large number of providers across the facility types said they were very interested in providing IUCD services.

Providers appeared knowledgeable about the conditions that should be checked or ruled out before inserting the IUCD. The majority in both hospitals and health centers mentioned pregnancy, infection and cervical or endometrial growth—with health center and hospital providers reporting these conditions in similar proportions.

When asked about supportive supervision, hospital providers were less likely to report having received supportive supervision than their health center counterparts in the past year. Further, while the majority of health center providers reported receiving supportive supervision specific to FP and IUCD services, less than half of hospital-based providers did so.

Provider experience of the IUCD revitalization initiative

Providers were asked to describe what they considered the challenges and successes of efforts to expand IUCD services. Quite a few challenges were mentioned by providers, however, the most common challenge frequently cited was the lack of awareness or knowledge of the IUCD. A notable proportion of these providers (21%) also said that there were no challenges to expanding IUCD services.

Successes reported by providers were just numerous. Demand creation was more likely to be cited as a success by hospital providers than health center providers, while creating community awareness of IUCD services was mentioned more often by health center providers than their hospital counterparts as a success.

Facility Client's Findings

A total of 1,186 women were interviewed, with 85% intercepted at health centers and the rest in hospitals. These results are based on female clients aged 15-49 who were seeking healthcare services on the day the evaluation team visited the health facility. For this reason, interpretation of the findings is restricted to facility clients, and may not be a reflection of the findings that could be obtained from population-level survey. Most hospital clients and urban health center clients were interviewed in Oromia and Addis Ababa, while in the rural health centers, Amhara, Oromia and SNNPR predominated.

Women's knowledge, use and experience with FP methods and services

Only 4% of the women interviewed reported not knowing any FP method. The remaining 96% of women across facilities reported awareness of injectables (94%), OCPs (86%), implants (80%), the IUCD (60%), condoms (32%), emergency contraception (7%), and unspecified others (2%). This pattern held for the health centers, but women interviewed at hospitals were just as aware of IUCDs as they were of implants (79% and 78%, respectively).

With regard to use, 25% of women reported that they had never used a modern FP method. Of these, 27% were clients sampled from urban health centers, 24% were sampled from

hospitals and 22% were sampled from rural health centers. Fewer than 10% of women were currently using OCPs. Implants superseded OCPs in current use, but injectables maintained predominance. Although 60% of the women reported knowledge of the IUCD, only 4% had ever or were currently using it.

Out of a total of 716 women who had ever heard of or knew about the IUCD, only 3% had ever used it (but discontinued use) and 4% were current users. Thus, a total of 7% of women were asked to share their direct experiences with IUCD. These women were also asked about their source(s) of information about the IUCD. The health facility was the dominant source of information (61%), followed by TV (42%). Additionally, 31% mentioned a friend/relative, and the same percentage also mentioned radio as a source of information about IUCD. Health Extension Workers (HEWs) were mentioned by 22% of the women as a source of information about IUCD overall, but women from rural health centers were more likely to mention HEWs, while TV and radio were more common non-health facility sources for hospital and urban health center clients.

Women's attitudes towards IUCD, regardless of their experience with the method, were obtained to determine if information campaigns and Information, Education and Communication (IEC) materials were effective. The most positive thing about IUCD for nearly 60% of the women was the fact that it prevented pregnancy for a long time. With the exception of the view that IUCD increases the risk of infection, stated by 10% of the women, all other negative opinions were stated by less than 10% of the respondents.

With regard to spousal consent, 92% of the women interviewed were affirmative that their partner should approve before she uses the IUCD. This suggests that the IEC materials, community mobilization and counseling should address men as much as they address the women.

Conclusion

In conclusion, the findings from this evaluation point to a number of successes in the initial phase of the IUCD initiative and provide lessons that should be taken into consideration during the expansion phase. The strong interest by the providers, the low level of negative opinions, low stock-outs of IUCD and other FP methods—all these factors point to a positive environment for IUCD scale-up.

BACKGROUND AND RATIONALE

From 2000 to 2011, lower fertility rates and increased family planning use have been documented in Ethiopia. The total fertility rate (TFR) decreased from 5.5 in 2000 to 4.8 in 2011.¹ Women's knowledge of at least one modern FP method is high at 97.1%, and the best known methods are injectables, condoms and pills. The percentage of married women using modern FP methods has doubled from 14% in 2005 to 27% in 2011. Injectables (21%) and implants (3%) are the most widely used methods.¹ Yet, much remains to be done towards achieving the country-level population goals of a TFR of 4 and contraceptive prevalence rate (CPR) of 65% by 2015.¹

The government of Ethiopia has advanced family planning (FP) as one strategy to improve maternal and child health and bring about overall development.² Accordingly, programs are being implemented to increase access to and demand for quality FP services through expansion of the contraceptive method mix--emphasizing long-acting methods at lower-level service delivery points.³ As part of this strategy, the FMOH launched, and is currently implementing Implanon and IUCD scale-up initiatives in the country. The aim of these initiatives is to expand voluntary access to long-acting FP methods, thereby increasing the method mix (from primarily short-term methods) and reducing unmet need for FP. Using the Health Extension Program (HEP) as a platform, the government began expanding FP options in 2009 with sub-dermal insertion of Implanon by HEWs.³ In 2010, the FMOH launched its initiative to revitalize the use of the IUCD by training clinical providers at health centers and hospitals. The IUCD revitalization initiative initially covered 100 woredas and by mid-2012 had increased to 116 woredas across the country.

In addition to capacity-building on long-term method provision for health providers, the FMOH has ensured continuous supply of FP commodities to health institutions and implemented activities to increase awareness of long-term FP methods through community mobilization efforts. Monitoring and evaluation (M&E) procedures have also been put in place to inform and guide these activities.

This report describes the findings from a midterm evaluation of the IUCD revitalization initiative. FHI 360 provided financial and technical support to the FMOH to conduct a process evaluation to: 1) determine if women are being targeted effectively by IUCD information campaigns and materials, and 2) to consolidate lessons learned from the initial implementation in 116 woredas to guide the national expansion. The lessons learned from this initial phase will guide the FMOH and implementing partners in developing strategies to improve family planning services and increase IUCD uptake in health facilities as well as in making informed programmatic decisions during scale-up.

¹ Central Statistical Authority and ICF International (2012), Ethiopia Demographic and Health Survey 2011, Addis Ababa, Ethiopia and Calverton, Maryland, USA

² Federal Democratic Republic of Ethiopia, Ministry of Health (2011) National guideline for family planning services in Ethiopia Addis Ababa, Ethiopia

³ Federal Democratic Republic of Ethiopia, Ministry of Health (2006) National Reproductive Health Strategy 2006- 2015), Addis Ababa, Ethiopia

OBJECTIVES

General Objective

The general objective of this process evaluation was to investigate progress of the IUCD revitalization initiative in focus woredas and to document and draw from lessons learned during the initial phase. These findings are expected to guide the scale-up of planning and nationwide implementation of IUCD services.

Specific evaluation objectives were laid out in the evaluation plan (see Appendix I) that addressed the general objective. However, this report will focus on areas of particular interest to the FMOH that include:

- Capacity and readiness of facilities (hospitals and health centers) to provide FP services
- Service statistics on insertion and removal of long-acting FP methods
- Individual provider capacity and experience in IUCD provision
- Female clients' general FP knowledge and experiences; attitudes towards and satisfaction with the IUCD
- Key informant (process owners/case team members, HEWs) reports on the successes and challenges of demand creation and initial scale-up activities

METHODOLOGY

Overview of the Evaluation

The midterm evaluation of the IUCD initiative was carried out using both quantitative and qualitative approaches. Semi-structured questionnaires were used to collect data from health providers and women of reproductive age at health facilities. Quantitative data also included a facility inventory and the collection of service statistics. Qualitative techniques were used to obtain information—via in-depth interviews—from HEWs and from family planning sub process owners/case team members at regional, zonal and woreda health offices. Data were collected from 30 woredas out of a total of 108 eligible woredas in the regions where the IUCD initiative had been implemented (see Table 1).

Evaluation Sample

Table 1: Distribution of sample woredas*

Regions	Total number of woredas	Proportion of eligible sample size (%)	Evaluation sample size		
			Rural woreda	Urban woreda	Total woredas
Amhara	26	24	5	2	7
Addis Ababa	10	9	0	3	3
Oromia	29	27	6	2	8
Dire Dawa	6	6	1	1	2
SNNPR	27	25	5	2	7
Tigray	10	9	2	1	3
Total	108	100	19	11	30

*Percentages and integers were rounded to the nearest whole number

The evaluation sites in each woreda were comprised of all hospitals and up to four health centers. If more than four health centers were found in a particular woreda, we purposively selected four to participate in the evaluation.

Data Collection and Analysis Procedures

Data collectors were trained for one week in February 2013. The first day of training included orientation to the evaluation and its objectives; the entire team of 45 data collectors was trained on research ethics and general data collector skills. On subsequent days of training and pilot testing, data collectors were divided into two groups: 32 who formed the quantitative team and 13 the qualitative team. Training was specific to their tasks and the data collection instruments they would manage independently.

Data collection took place during the month of March 2013. Quantitative data collectors conducted facility inventories, collected service statistics, and administered provider and female client interviews at selected hospitals and health centers. A team of three data collectors was assigned to each evaluation site on the days of data collection. Two data collectors were instructed to approach every woman who appeared to be of reproductive age. Female clients receiving any type of health service at the facilities were intercepted and screened for age and willingness to participate in the evaluation. Women were eligible to participate in the study if they were of reproductive age (15-49). All eligible and consenting women were enrolled. If service points were scattered around the facility, the two interviewers would circulate among the service points, intercepting women at each until they reached the quota of 10 women per facility. On busy days or at large, dispersed or high-volume facilities, this meant data collectors could not feasibly intercept every eligible woman at every service point. Instructing interviewers to intercept any woman of reproductive age when not engaged, however, decreased the chances of selection bias, as the choice of participant was not left up to the interviewer.

The third member of the quantitative data collection team interviewed providers, conducted the facility inventory and collected service statistics, working with a designated staff member at the health facility.

The qualitative team of 13 data collectors included four supervisors who each headed up a data collection unit. Therefore, a unit was made up of three or four data collectors. For in-depth, key informant interviews, the qualitative team—working with their trainer/fieldwork coordinator--selected a convenience sample of HEWs and maternal and child health sub process owners/case team members. The latter were selected from regional, zonal and woreda health offices, while two HEWs per woreda were chosen to participate in interviews. As quantitative data collectors carried out their tasks at health facilities, qualitative data collectors in the same woreda independently interviewed these key informants, took field notes and sent the information electronically to the fieldwork coordinator based in Hawassa, Ethiopia.

Quantitative data were entered, managed and analyzed using SPSS version 17.0. Qualitative data were analyzed using NVivo, version 10. Analyses were performed in-house at the offices of FHI 360/Ethiopia.

EVALUATION FINDINGS

In this section, we provide brief descriptions of the key results from this evaluation. For a more comprehensive understanding of the findings, please refer to the tables appended at the end of the narrative.

QUANTITATIVE RESULTS

All results for the facility inventory, service statistics, provider interviews and client interviews are presented in tables stratified by health facility. Therefore, frequencies and proportions are shown for hospitals, rural health centers and urban health centers. Unlike service statistics, the facility inventory, provider and client interviews are based on a subset of those particular target populations. As such, and particularly for female health facility clients, they are not representative of the total population.

Capacity And Readiness Of Facilities To Provide FP Services

Results on the capacity and readiness to provide FP services are based on information collected from facility inventories. Eighteen hospitals, 34 urban health centers and 68 rural health centers were included in the evaluation for a total of 120 health facilities. Most of the facilities in the evaluation were located in Oromia followed by Amhara and SNNPR (see Table 2).

EngenderHealth was the partner organization that supported most of these facilities (38%). Ipas and IFHP together supported another 38%. MSIE supported with the fewest facilities (8%) and other organizations accounted for another 11% (see Table 2).

Provider training

The number of providers who received IUCD training before and after January 2010 was documented. In hospitals in the six regions, 18 providers ranging from clinical nurses, midwives, health officers and general practitioner/specialists received IUCD training before January 2010 vs. 28 who received this training after that date. In health centers with the same type of health professionals, a total of 29 providers in urban and 56 providers in rural health centers had received IUCD training before January 2010. After that date, the numbers increased to 100 providers in urban health centers and 74 in rural health centers. Thus, there were substantial increases in the number of providers trained after January 2010: 55% increase in hospitals, over 200% increase in urban health centers and 32% increase in rural health centers (see Table 3).

Certification of health professionals who provide IUCDs was also documented. Of those currently working in the facilities evaluated, 221 were trained and certified to provide IUCDs: 18% in hospitals, 46% in urban health centers and 37% in rural health centers. Health professionals who were trained but not certified to provide IUCDs were fewer in number at 75: 13% in hospitals, 17% in urban health centers and 69% in rural health centers (see Table 4).

In order to get a sense of the availability of staff and client access to IUCD services, data were collected on the number of trained and certified IUCD providers who worked fulltime in the facility and who were actually on duty at the time the facility inventory was administered onsite. There were a total of 168 full-time trained and certified providers across the three facility types: 26 in hospitals, 67 in urban health centers and 75 in rural health centers. Most of the providers were diploma clinical nurses and midwives. Regarding the number of fulltime providers (not necessarily IUCD only providers but also providers of all FP methods) who were actually onsite during the facility inventory, there were 20% in hospitals, 25% in urban health centers and 55% in rural health centers (see Table 4). This number is however affected by the sample size for each facility type. Most of the health centers surveyed were located in rural areas.

Readiness to provide family planning and IUCD services

Family planning methods provided by FMOH facilities include short-acting and long-term methods. Oral and emergency contraceptive pills, injectables, and condoms constitute the short-term methods. The implants: Implanon, Jadelle and Trust as well as the IUCD complete the facilities' repertoire of longer-term contraceptive methods. All 18 hospitals in the inventory provided OCPs, injectables and Implanon. Between 56% and 89% of hospitals provided the remaining methods. In urban health centers, more than 90% provided all methods except emergency contraceptive pills (ECPs; 79%) and Trust implants (76%). In rural health centers, injectables were provided in all 68 facilities. OCPs, Implanon and condoms were provided in over 90% of these health centers, while IUCDs were provided in 79%. Permanent FP methods: vasectomy and tubal ligation, were provided in 67% and 72% respectively hospitals, but very few rural health centers (6%) provided it.

An indicator of immediate access was obtained by taking an audit of which FP methods were available on the day the facility inventory was administered. In hospitals, all had OCPs, injectables, Implanon, IUCDs and condoms. In urban health centers, over 90% had OCPs, injectables, Implanon, IUCD and condoms. Comparatively, only OCPs, injectables and

condoms were available in over 90% of the rural health centers. Comparatively, only OCPs, injectables and condoms were available in over 90% of the rural health centers; the other methods—IUCDs were available in 79%, Implanon in 84% and Jadelle and Trust Implant in 56%. Thus, in the three types of facilities, 87% had IUCDs on hand when the facility inventory was administered (see Table 5).

Method stock-outs are also an important indicator of readiness to provide FP services. In the last six months, very few facilities were without IUCDs. Only one hospital, one rural health center and one urban health center reported that they had experienced stock outs of that method at some point in the last six months. Pills and implants were more likely to have been out of stock in the last six months, but with the exception of Jadelle and Implanon, most methods did not experience notable stock-outs (see Table 5).

Particularly for the IUCD, equipment other than the method itself is necessary for provision. Sterilization tools, examination beds, gynecology lamp or torch and a device to measure blood pressure are needed to safely and properly provide the IUCD. On the day of the facility inventory, the availability of equipment in storage or in the MCH/FP unit was recorded. All facility types had examination beds and most had the means to measure blood pressure and sterilize equipment. However, less than half of rural health centers had a gynecology lamp or torch (see Table 5).

Availability of IEC materials

Information, education and communication materials are helpful to guide counseling and provide information to FP clients. Flip charts, brochures, posters and leaflets serve as tools for both provider and client who can use them to discuss and decide upon appropriate contraceptive methods. In hospitals and urban and rural health centers, posters and flipcharts were common. Brochures and leaflets, which are materials that clients can take home, tended to be less available. Overall, urban health centers and hospitals had a broader array of IEC materials than the rural health centers. IEC materials in health centers were more likely to contain information on injectables and IUCD than materials in hospitals. In general, the methods presented in these materials most often were injectables, the IUCD, OCPs, Implanon and condoms--in order of decreasing prevalence (see Table 6).

Service Statistics On Insertion And Removal Of Long-Acting FP Methods

Service statistics on insertion and removal of LAFP methods were collected for calendar year 2012 from all evaluation facilities. Insertion and removals of the IUCD, Implanon, Jadelle, Trust and unspecified implants were recorded quarterly. As Table 7 shows, there were 4,202 insertions of the IUCD or implants in the 18 hospitals, with majority of the insertions performed for Implanon and 20% for the IUCD. In health centers, the majority of insertions were of Implanon as well, with 20% and 30% accounting for IUCD insertions in urban and rural health centers, respectively (see Table 7).

In hospitals, of all removals of LAFP methods, removals were much lower in number, with Implanon again accounting for most procedures across all facility types. In hospitals, of all removals of LAFP methods, IUCDs constituted 12%, while in urban and rural health centers, they accounted for 3% and 8%, respectively (see Table 7).

Individual Provider Capacity And Experience In IUCD Provision

Provider background

Providers were selected to participate in interviews from the three types of facilities. Thirty providers in hospitals, 67 in urban health centers and 87 in rural health centers were interviewed for a total of 184 providers from 120 facilities. Most providers in hospitals were interviewed in Oromia, while in urban health centers, most were interviewed in Addis Ababa. In rural facilities, most of the interviews were conducted in Amhara region (see Table 8).

Whether hospital or health center, the majority of providers were female and married. In rural health centers, however, the proportion of male and female providers was almost equal (47% and 53%, respectively), as were married and single providers in both types of health centers. Religious affiliation was likewise consistent across facilities: the majority was Orthodox with Protestants being the second most common affiliation mentioned. Muslims and Catholics combined made up 7% of the total religious affiliation of providers (see Table 8).

In line with the facility inventory, most of the providers were clinical nurses and diploma midwives. Of that number, clinical nurses with diploma were the most numerous. Notably, no medical doctors were interviewed, and in urban health centers, 18% of providers were health officers (see Table 9). The average length of time working as a health service provider was 10 years for hospital-based providers, 9 for those in urban health centers and 5 for those working in rural facilities. With regard to average length of time working in their current facility, hospital providers reported 7 years, their urban health center counterparts 5, and rural health center providers 3 years. Thus, there appears to be longevity and some stability in service provision at the provider's current facility. Finally, the overwhelming majority of providers were assigned to the Maternal and Child Health unit (MCH), with Delivery as the second most reported assignment. There were few reports of assignments to the Out Patient Department, emergency and inpatient units, and to others that were not anticipated (ART, health care unit, health center and health prevention head, matron, TB, VCT, and under 5 children unit) (see Table 9).

Provider capacity and comfort with IUCD provision

Providers reported conducting IUCD insertions on a regular basis. In hospitals, the average number of insertions was 36 in the past year. Health center providers reported higher average insertions than hospital providers: 48 by urban and 37 by rural health center providers in the past year. As such, providers perform three to four IUCD insertions per month (see Table 10).

As documented in the service statistics, there are many more insertions of LAFP methods than removals, and more implant removals than IUCD removals. According to provider reports, the main reasons that women request IUCD removal are for fear of complications, heavy bleeding, and desire for pregnancy (see Table 10), with heavy bleeding cited most often. Of note, the majority of providers interviewed (58%) reported that they had not performed any IUCD removals (see Table 10).

Providers were also asked about their level of comfort and interest in providing IUCD services. Over two-thirds of providers who were asked about their comfort level reported being very comfortable providing IUCD insertions. Another 12% said they were somewhat comfortable. A similarly large number of providers across the facility types said they were very interested in providing IUCD services (see Table 11).

Providers' level of comfort and interest in providing IUCD services may be linked to their knowledge of contraindications to IUCD use and whether supportive supervision is provided to them. Providers were asked to identify conditions that should be checked or ruled out

before inserting the IUCD. The majority in both hospitals and health centers mentioned pregnancy, infection and cervical or endometrial growth--with health center and hospital providers reporting these conditions in similar proportions (see Table 12). About half of them also mentioned checking uterine size and depth. Conditions such as prolonged and heavy bleeding, anemia and others were mentioned by fewer than 50% of providers.

With regard to supportive supervision, hospital providers were less likely to report having received supportive supervision than their health center counterparts in the past year. Further, while the majority of health center providers reported receiving supportive supervision specific to FP and IUCD services, less than half of hospital-based providers did so (see Table 12).

Provider experience of the IUCD revitalization initiative

Providers were asked to describe what they considered the challenges and successes of efforts to expand IUCD services. Quite a few challenges were mentioned by providers, as illustrated in Table 13, but only one stood out consistently and frequently among the providers of all facility types: lack of awareness or knowledge of the IUCD. A notable proportion of these providers (21%) also said that there were no challenges to expanding IUCD services.

Successes reported by providers were just as numerous (see Table 13), but the consistency across the provider types was not as evident. Creating an increase in the number of users was more likely to be cited as a success by hospital providers than health center providers, while creating community awareness of IUCD services was mentioned more often by health center providers than their hospital counterparts. It is interesting to note that this issue of awareness of IUCD services was mentioned simultaneously as a challenge and as an element of success by these providers, as were others such as manpower and supply.

Clients' Knowledge And Experience With FP And The IUCD

Client background

Female clients receiving any service at hospitals or health centers in the six regions were intercepted at random and asked to participate in the evaluation. A total of 1,186 women were interviewed, with 85% intercepted at health centers. Most hospital clients and urban health center clients were interviewed in Oromia and Addis Ababa, while in rural health centers Amhara, Oromia and SNNPR predominated (see Table 14).

The majority of women across all facility types was married and between 21 and 30 years of age, with a mean of 27 years. Like providers, most women's religious affiliation was Orthodox, with Protestants coming in a distant second. Unlike providers, however, there was a larger proportion of Muslims in the client sample. Educational attainment varied by facility type with hospital clientele more likely than counterparts from urban and rural health centers to have completed secondary education or higher and almost 50% of women at rural health centers reporting no school attendance(see Table 14).

Women's knowledge, use and experience of family planning methods and services

Interviewers asked women to name the family planning methods they know. Only 4% reported that they knew none. The remaining 96% of women across facilities reported awareness of injectables (94%), OCPs (86%), implants (80%), the IUCD (60%), condoms (32%), emergency contraception (7%), and unspecified others (2%). This pattern held for the

health centers, but women interviewed at hospitals were just as aware of IUCDs as they were of implants (79% and 78%, respectively) (see Table 15).

With regard to use, 25% of women reported that they had never used a modern FP method. Most of the non-users were clients at urban health centers (27%), but hospital-based (24%) and rural health center-based women (22%) were not far behind. As may be gathered from their greater awareness of injectables, the majority of women had used injectable contraception at some time (60%), with ever use of methods following the same pattern of prevalence described above. However, ever use of the IUCD was equal to condoms as ever use of both methods was reported by 4% of women.

Patterns of current modern method use were quite different among the smaller subset of women for whom this situation was applicable. Fewer than 10% of women were currently using OCPs. Indeed, implants superseded OCPs in current use, but injectables maintained their predominance, (see Table 15). In spite of 60% of women reporting knowledge of the IUCD, only 4% had ever or were currently using the method.

Women who had never used or were not currently using a modern family planning method were asked the reason(s) for their decision. Table 16 lists the responses across the three types of facilities. The numbers are fairly low for all reasons except for the 39% who said that they don't have a partner/husband currently and the desire to get pregnant, which was reported by 25% of women. For women who reported ever or currently using family planning, we asked whether they had experienced problems getting the type of method they wanted. Most of them reported that they experienced no problems, but a small number cited stock-outs, lack of transportation to clinic, or provider denial as barriers to receipt of their chosen method (see Table 16).

Women's experiences with and opinions of the IUCD

Women who had knowledge of the IUCD responded to additional questions in the interview. First they were asked if they had ever used, previously used or were currently using the IUCD. Out of a total of 716 women who had ever heard of or knew about the IUCD, only 3% had ever used it and 4% were currently using the method for a total of 7% of women who would be able to share their direct experiences with the method. These women were also asked about their source(s) of information about the IUCD. The health facility was the predominant source (61%) followed by TV (42%), and in equal measure friend/relative or radio (31%). HEWs accounted for 22% of the reports in general, but as expected, women from rural health centers were more likely to mention them as their source of IUCD information, while TV and radio were more common non-health facility sources for hospital and urban health center clients. (see Table 17).

Women's attitudes towards the IUCD, regardless of their experience with the method, were obtained to determine if information campaigns and IEC materials were effective. We asked what positive and negative things they know or had heard about the IUCD. About 25% of women said they had heard or know nothing positive of the method, while 64% reported nothing negative. Thus, a greater proportion of these women appear to be positively inclined (or at least neutral) towards the IUCD. Specifically, women's main positive reports were:

- Prevents pregnancy for a long time (58%)
- Very effective method (25%)

- Does not affect fertility (25%)
- Contains no hormones like injectables and pills (17%)
- Requires low maintenance (11%)
- Cost-effective/affordable (1%)

As Table 18 shows, except for cost- and method-effectiveness, hospital and urban health center clients were more likely to endorse these items than women interviewed at rural health centers.

Specific reports of negative things heard or known about the IUCD were:

- Increases risk of infection (10%)
- Increases risk of fertility (9%)
- Might fall out after insertion (7%)
- IUCD will feel uncomfortable (6%)
- IUCD will move to other parts (5%)
- Painful insertion/fear of insertion (3%)
- Partner will feel IUCD during sex (3%)
- Pelvic exam invasive/embarrassing (1%)
- Baby can be born with IUCD in body (1%)

Thus, it is heartening to see that negative information about the IUCD is mentioned less frequently than positive by these women and that much of it can be addressed by providing accurate information and dismissing myths (see Table 18).

Another item that provides guidance on next steps for the initiative is women's response to the questions of whether or not a woman's partner should approve before she uses the IUCD. Ninety-two percent said yes, which is a strong indicator that IEC materials, community awareness programs, and other efforts to expand IUCD use need to include men. Because women interviewed at rural health centers were more likely to say yes, activities may need to be more pronounced in those geographic areas as well.

Finally, our sample of women who reported currently using the IUCD was very small, but we asked if they experienced any health issues that they would attribute to its use. Of 30 women, 67% said they have not experienced any health issues. The remainder cited heavy bleeding, abdominal pain, expulsions, infections and other reasons that ranged from other types of pain and menstrual irregularities (see Table 19). Women were satisfied with the provider who inserted the IUCD, however, as affirmed by 97% of the sample.

QUALITATIVE RESULTS

Key Informants Perspectives On The Successes And Challenges Of Initial IUCD Scale-Up Activities

The qualitative results based on in-depth interviews with 60 HEWs and 55 process owners/case team members are described in a separate report, [*Midterm Evaluation of the*

IUCD Scale-Up Initiative in Ethiopia - Report on Key Informant In-Depth Interviews]. The key findings are:

- While there are plans for the scale-up of IUCD provision, but they are in different states of readiness for implementation
- Key informants stated that the community has low awareness of the IUCD, but acknowledged that awareness is increasing
- Demand creation for the IUCD is in its early stages and much still needs to be done
- HEWs report that myths and misconceptions about the IUCD pose challenges as women often pay more attention to peers or stories about negative outcomes of IUCD use than to counseling
- HEWs believe that lack of two-way referral system and feedback from health facilities hampers their ability to promote the IUCD
- HEWs report that lack of training on the IUCD also affects their ability to create awareness and demand for the method in their communities
- Supportive supervision for HEWs and process owners varies from place to place, ranging from regular integrated support meetings and sensitization workshops to no supervision at all
- Long distances to health centers and multiple required visits reduces the potential for IUCD acceptance and uptake
- Both process owners and HEWs feel monitoring and evaluation system for IUCD could be improved so they can remain informed and guided by scale-up progress
- Aspects of IUCD provision or use are aversive to users such as exposing body to health workers (particularly males) and checking the IUCD strings
- Husbands/partners as well as religious beliefs are barriers to IUCD use

CONCLUSIONS AND RECOMMENDATIONS

This study was conducted with a primary objective of determining the progress of the IUCD revitalization initiative in the initial focus woredas, and to document and draw from lessons learned during the initial phase. The findings from this evaluation indicate a successful implementation of the IUCD initiative in the focus woredas. Results on training of personnel in IUCD services show that in the 120 facilities surveyed, 221 providers had received training in IUCD services, implying an average of 1.84 trained IUCD providers per facility. This result suggests availability of trained personnel to deliver IUCD services. There is evidence of a small sample of providers who had received training in IUCD services but who were not certified, calling for a follow-up mechanism to ensure that such providers complete the certification requirements in order to be authorized to provide IUCD services. Providers were generally very interested in IUCD service provision, which demonstrates a very positive aspect of promoting use of IUCD as an additional LAFP method to the Implants.

In terms of infrastructure and product availability, results were also encouraging, again an indication of a successful initiation of the program. Availability of IUCDs at the facilities ranged from 79%-97%, which was competitive enough with the main methods (injectables, Implanon, OCPs). The necessary equipment for IUCD services delivery were also widely available. Therefore, from the training and general readiness perspective, the findings show a major success in the IUCD initial phase activities.

A comparative analysis of the uptake of LAFP methods shows that Implanon was the leading LAFP method dispensed in 2012 (49%), but IUCD had quickly attained a significant share of clients (25%), making the two methods the most dispensed in 2012. This can mostly be attributed to the success in the training and awareness creation activities. Most importantly, these results show evidence of interest in LAFP methods. Comparatively, we also noted that the level of removals of IUCD was very low. While the study did not investigate more detail on IUCD removals, it is possible that retention of IUCD is very high. This may also be because the insertions may have only been received recently.

Dissemination of IEC materials about IUCD to health facilities has also been a major success. Between 78% and 97% of the facilities had IUCD IEC materials. However, providers cited low levels of awareness about IUCD in their communities, implying a need for increased awareness creation interventions. Among the women who knew about the IUCD (60% awareness of IUCD among women interviewed), over 50% had no negative misconceptions about IUCD. A common perception is that misconceptions about IUCD are widespread. However, key informants interviewed for the qualitative component of the study suggested misconceptions as a limiting factor for IUCD uptake. An important finding that has implications for the design of IUCD communication materials is the fact that nearly all women want their spousal approval prior to their use of IUCD. Thus the communication campaign should equally target men.

Overall, the findings from this evaluation suggest that the approaches used during the initial phase are replicable. An important focus is to increase the awareness creation activities. The interest from providers to deliver IUCD services is positive and should be further encouraged and strengthened.

Tables

Table 2: Regional distribution of facilities and partners

Facility descriptive table	Hospital		Health Centers						Total	
	Count	%	Urban		Rural		HC Total		Count	%
			Count	%	Count	%	Count	%		
Tigray	2	11	2	6	8	12	10	10	12	10
Amhara	1	6	6	18	19	28	25	24	26	22
Oromia	5	28	7	21	21	31	28	27	33	27
SNNP	4	22	2	6	20	29	22	22	26	22
Addis Ababa	5	28	11	32	0	0	11	11	16	13
Dire Dawa	1	6	6	18	0	0	6	6	7	6
Total	18	100	34	100	68	100	102	100	120	100
Distribution of facility partners										
None	3	14	0	0	6	7	6	5	9	6
EngenderHealth	8	38	17	45	28	35	45	38	53	38
Marie Stopes International	1	5	0	0	10	12	10	8	11	8
IPAS	4	19	11	29	11	14	22	18	26	19
IFHP	3	14	7	18	16	20	23	19	26	19
Other	2	10	3	8	10	12	13	11	15	11
Total	21	100	38	100	81	100	119	100	140	100

N.B. There is double partner support in some health facilities.

The other partners include: World Vision, USCD, MSH, MANEP, L10K, Kocia (3), JHEPIGO, Intra Health (3), ICAP, Family Guidance Association, and CORHA.

Table 3: Provider training before and after January 2010

Facility Inventory survey	Hospital	Health Centers			Total
		Urban	Rural	HC Total	
	Count	Count	Count	Count	Count
Providers who have had IUCD training before January 2010					
Clinical nurses (diploma)	8	18	18	36	44
Clinical nurses (BSc)	3	17	0	17	20
Midwives (diploma)	6	4	9	13	19
Midwives (BSc)	0	2	0	2	2
Health officers	0	15	2	17	17
General practitioner/specialist	1	0	0	0	1
Total across all provider classifications	18	56	29	85	103
Providers who have had IUCD training since January 2010 as part of the IUCD scale-up initiative training					
Clinical nurses (diploma)	12	32	62	94	106
Clinical nurses (BSc)	2	14	4	18	20
Midwives (diploma)	6	15	30	45	51
Midwives (BSc)	3	3	1	4	7
Health officers	1	10	3	13	14
General practitioner/specialist	4	0	0	0	4
Total across provider classifications	28	74	100	174	202

Table 4: Health service providers' training, certification and employment status

Facility Inventory survey	Hospital	Health Centers			Total
		Urban	Rural	HC Total	
	Count	Count	Count	Count	Count
Providers who have been trained and certified on IUCD are currently working in the facility					
Clinical nurses (diploma)	13	39	50	89	102
Clinical nurses (BSc)	3	26	5	31	34
Midwives (diploma)	16	13	20	33	49
Midwives (BSc)	3	2	3	5	8
Health officers	0	21	3	24	24
General practitioner/specialist	4	0	0	0	4
Total across all provider classifications	39	101	81	182	221
Providers who have been trained but not certified on IUCD are currently working in the facility					
Clinical nurses (diploma)	5	7	30	37	42
Clinical nurses (BSc)	1	2	1	3	4
Midwives (diploma)	2	3	18	21	23
Midwives (BSc)	1	1	1	2	3
Health officers	1	0	2	2	3
General practitioner/specialist	0	0	0	0	0
Total across all provider classifications	10	13	52	65	75
Providers who have been trained and certified on IUCD AND are currently working FULL-TIME in the facility					
Clinical nurses (diploma)	8	30	48	78	86
Clinical nurses (BSc)	4	16	2	18	22
Midwives (diploma)	12	12	19	31	43
Midwives (BSc)	2	1	4	5	7
Health officers	0	8	2	10	10
General practitioner/specialist	0	0	0	0	0
Total across all provider classifications	26	67	75	142	168
Providers who are currently working full-time in the FP/MCH unit that were on duty on the day of the survey					
Clinical nurses (diploma)	21	38	92	130	151
Clinical nurses (BSc)	11	8	3	11	22
Midwives (diploma)	23	21	60	81	104
Midwives (BSc)	2	1	3	4	6
Health officers	2	5	2	7	9
General practitioner/specialist	1	0	0	0	1
Total across all provider classifications	60	73	160	233	293

Table 5: Method and equipment availability by facility

FP methods provided in this facility	Hospital		Health Centers						Total	
	Count	%	Urban		Rural		HC Total		Count	%
			Count	%	Count	%	Count	%		
OCPs	18	100	33	97	65	96	98	96	116	97
Injectables	18	100	34	100	68	100	102	100	120	100
Implanon	18	100	34	100	65	96	99	97	117	98
Jadelle	14	78	33	97	47	69	80	78	94	78
Trust implant	10	56	26	76	40	59	66	65	76	63
IUCDs	16	89	33	97	54	79	87	85	103	86
Condoms	16	89	32	94	64	94	96	94	112	93
Emergency contraceptive pills	14	78	27	79	48	71	75	74	89	74
Vasectomy	12	67	0	0	4	6	4	4	16	13
Tubal ligation	13	72	0	0	4	6	4	4	17	14
Total	18	NA	34	NA	68	NA	102	NA	120	NA
FP methods available on the day of the visit										
OCPs	18	100	32	94	63	93	95	93	113	94
Injectables	18	100	33	97	66	97	99	97	117	98
Implanon	18	100	32	94	57	84	89	87	107	89
Jadelle	11	61	23	68	38	56	61	60	72	60
Trust implant	9	50	24	71	38	56	62	61	71	59
IUCDs	17	94	33	97	54	79	87	85	104	87
Condoms	17	94	33	97	62	91	95	93	112	93
Emergency contraceptive pills	14	78	25	74	41	60	66	65	80	67
Total	18	NA	34	NA	68	NA	102	NA	120	NA
FP methods stock outs at any time in the past six months										
OCPs	3	17	6	18	7	10	13	13	16	13
Injectables	3	17	2	6	4	6	6	6	9	8
Implanon	1	6	4	12	9	13	13	13	14	12
Jadelle	6	33	18	53	16	24	34	33	40	33
Trust implant	1	6	8	24	3	4	11	11	12	10
IUCDs	1	6	1	3	2	3	3	3	4	3
Condoms	1	6	0	0	2	3	2	2	3	3
Emergency contraceptive pills	1	6	3	9	8	12	11	11	12	10
Total	18	NA	34	NA	68	NA	102	NA	120	NA
Equipment available in the MCH/FP unit or store room										
Blood pressure apparatus	16	89	30	88	58	85	88	86	104	87
Gynecology lamp or torch	12	67	20	59	31	46	51	50	63	53
Examination bed	17	94	34	100	66	97	100	98	117	98
Sterilizing equipment	10	56	29	85	54	79	83	81	93	78
None	0	0	0	0	1	1	1	1	1	1
Total	18	NA	34	NA	68	NA	102	NA	120	NA
IEC materials available in MCH/FP unit										
Flip chart	13	72	28	82	52	76	80	78	93	78
Brochure	11	61	18	53	33	49	51	50	62	52
Poster	16	89	34	100	55	81	89	87	105	88
Leaflets	11	61	21	62	33	49	54	53	65	54
Total	18	NA	34	NA	68	NA	102	NA	120	NA

Table 6: IEC materials available and methods described

Methods described on the IEC material	Hospital		Health Centers						Total	
	Count	%	Urban		Rural		HC Total		Count	%
			Count	%	Count	%	Count	%		
OCPs	15	83	33	97	54	79	87	85	102	85
Injectable	15	83	33	97	58	85	91	89	106	88
Implanon	15	83	33	97	51	75	84	82	99	83
Jadelle	13	72	28	82	43	63	71	70	84	70
Trust Implants	12	67	20	59	31	46	51	50	63	53
IUCDs	14	78	33	97	56	82	89	87	103	86
Condoms	14	78	31	91	53	78	84	82	98	82
Emergency contraceptive pills	10	56	27	79	33	49	60	59	70	58
Vasectomy	11	61	23	68	39	57	62	61	73	61
Tubal ligation	12	67	23	68	38	56	61	60	73	61
Other	1	6	3	9	7	10	10	10	11	9
Total	18	NA	34	NA	68	NA	102	NA	120	NA

Table 7: Number of clients who received and removed LAFP methods in 2012

Number of clients who received LAFP methods	Hospital		Health Centers						Total	
	Count	%	Urban		Rural		HC Total		Count	%
			Count	%	Count	%	Count	%		
LAFP Methods										
IUCD	830	20	3032	20	4981	30	8013	25	8843	25
Implanon	2333	56	8899	58	6317	38	15216	48	17549	49
Jadelle	762	18	1411	9	2043	12	3454	11	4216	12
Trust Implant	260	6	1966	13	3091	19	5057	16	5317	15
Implant unspecified type	17	0	21	0	127	1	148	0	165	0
Total	4202	100	15329	100	16559	100	31888	100	36090	100
Number of clients who removed LAFP methods										
LAFP Methods										
IUCD	109	12	226	8	95	3	321	6	430	7
Implanon	607	66	1740	63	2060	72	3800	68	4407	68
Jadelle	108	12	359	13	297	10	656	12	764	12
Trust Implant	21	2	100	4	58	2	158	3	179	3
Implant unspecified type	49	5	167	6	175	6	342	6	391	6
Norplant	29	3	167	6	160	6	327	6	356	5
Total	923	100	2759	100	2845	100	5604	100	6527	100

Table 8: Demographic characteristics of provider

Providers descriptive table	Hospital		Health Centers						Total	
	Count	%	Urban		Rural		HC Total		Count	%
			Count	%	Count	%	Count	%		
% distribution of providers by region										
Tigray	4	13	3	4	13	15	16	10	20	11
Amhara	1	3	12	18	29	33	41	27	42	23
Oromia	12	40	15	22	22	25	37	24	49	27
SNNP	5	17	2	3	23	26	25	16	30	16
Addis Ababa	6	20	24	36	0	0	24	16	30	16
Dire Dawa	2	7	11	16	0	0	11	7	13	7
Total	30	100	67	100	87	100	154	100	184	100
% distribution provider by sex										
Male	8	27	17	25	41	47	58	38	66	36
Female	22	73	50	75	46	53	96	62	118	64
Total	30	100	67	100	87	100	154	100	184	100
Average age of provider in years (mean)	31		30		26		28		29	
% distribution of provider by marital status										
Single	9	30	31	46	36	41	67	44	76	41
Married	20	67	34	51	48	55	82	53	102	56
Divorced / Separated / Widowed	1	3	2	3	3	4	5	3	6	3
Total	30	100	67	100	87	100	154	100	184	100
% distribution of provider by religion										
Orthodox	15	50	52	78	50	58	102	66	117	64
Muslim	1	3	3	4	8	9	11	7	12	6
Protestant	14	47	12	18	28	32	40	26	54	29
Catholic	0	0	0	0	1	1	1	1	1	1
Total	30	100	67	100	87	100	154	100	184	100

Table 9: Provider position, length of service and departmental assignment

	Hospital		Health Centers						Total	
	Count	%	Urban		Rural		HC Total		Count	%
			Count	%	Count	%	Count	%		
% distribution of providers by region										
Clinical nurse (diploma)	13	44	30	45	47	54	77	50	90	49
Clinical nurse (BSc)	3	10	9	13	3	3	12	8	15	8
Midwife (diploma)	9	30	13	19	33	38	46	30	55	30
Midwife (BSc)	3	10	2	3	1	0	3	2	6	3
Health officer	1	3	12	18	1	0	13	8	14	8
Other	1	3	1	2	2	2	3	2	4	2
Total	30	100	67	100	87	100	154	100	184	100
Provider average length of time working in the health service in years (mean)	10		9		5		7		7	
Provider average length of time working in this health facility in years (mean)	7		5		3		4		4	
Provider's health unit assigned										
Delivery	8	27	5	7	16	18	21	14	29	16
MCH	19	64	49	73	65	75	114	74	133	72
OPD	1	3	2	3	4	5	6	4	7	4
Emergency	0	0	1	2	0	0	1	0	1	0
Inpatient	1	3	0	0	0	0	0	0	1	0
Other	1	3	10	15	2	2	12	8	13	7
Total	30	100	67	100	87	100	154	100	184	100
Others include: ART (5), Health care unit, Health Center head (2), Health prevention head, matron, TB section, Under 5 children section, VCT										

Table 10: Number of IUCD insertions and women’s main reasons reported by providers for removals

Average No. of IUCD insertions personally performed by providers in the past year	Hospital		Health Centers						Total	
	Count	%	Urban		Rural		HC Total		Count	%
			Count	%	Count	%	Count	%		
Average	36		48		37		43			
Total	30	NA	87	NA	67	NA	154	NA	184	NA
Main reasons for removals										
Not performed removal	14	47	58	67	34	51	92	60	106	58
Fear of complication	6	20	14	16	7	10	21	14	27	15
Heavy bleeding	9	30	22	25	28	42	50	33	59	32
Want pregnancy	5	17	14	16	14	21	28	18	33	18
Other...	2	7	4	5	6	9	10	7	12	7
Total	30	NA	87	NA	67	NA	154	NA	184	NA
Others include: Weight loss, Has no sexual partner/Not sexually active (3), Fear of husband/Disapproval from husband (5), STD (Sexual transmitted diseases) (2), Getting pregnant while loop is still there										

Table 11: Provider’s level of comfort and interest in providing IUCD

Providers level of comfort in providing IUCD	Hospital		Health Centers						Total	
	Count	%	Urban		Rural		HC Total		Count	%
			Count	%	Count	%	Count	%		
Don't provide IUCD insertion	5	17	19	22	6	9	25	16	30	16
Very comfortable	20	67	57	66	48	72	105	68	125	68
Somewhat comfortable	4	13	10	12	8	12	18	12	22	12
Neither comfortable nor uncomfortable	0		0		2	3	2	1	2	1
Somewhat uncomfortable	1	3	1	1	2	3	3	2	4	2
Uncomfortable	0		0		1	2	1	1	1	1
Total	30	100	87	100	67	100	154	100	184	100
Providers level of interest in providing IUCD										
Very interested	28	94	82	94	59	88	141	92	169	92
Somewhat interested	1	3	5	6	5	8	10	6	11	6
Neither interested nor disinterested	1	3	0		0		0		1	
Somewhat disinterested	0		0		3	4	3	2	3	2
Very disinterested	0		0		0		0		0	
Total	30	100	87	100	67	100	154	100	184	100

Table 12: Provider’s knowledge of safe IUCD provision and receipt of supportive supervision

Things to be checked before providing a woman with IUCD insertion services	Hospital		Health Centers						Total	
	Count	%	Urban		Rural		HC Total		Count	%
			Count	%	Count	%	Count	%		
Do not provide IUCD insertions	3	10	18	21	3	5	21	14	24	13
Pregnancy	26	87	59	68	56	84	115	75	141	77
Uterine size and depth	18	60	38	44	39	58	77	50	95	52
History of prolonged/heavy bleeding	13	43	32	37	35	52	67	44	80	44
Infection	25	83	59	68	59	88	118	77	143	78
Cervical or endometrial growth	21	70	45	52	43	64	88	57	109	59
Anemia	11	37	17	20	17	26	34	22	45	25
Other ...	2	7	11	13	8	12	19	12	21	11
Total	30	NA	87	NA	67	NA	154	NA	184	NA
Others include: Checkup of other health related issues(10), STI(8), Menstrual cycle(2), Virginity										
Supportive supervision provided in past year										
Yes	13	43	48	55	45	67	93	60	106	58
No	17	57	35	40	20	30	55	36	72	39
Don't know	0		4	5	2	3	6	4	6	3
Total	30	100	87	100	67	100	154	100	184	100
Family planning /IUCD service covered during supportive supervision										
Yes	13	43	46	53	43	64	89	58	102	56
No	0		2	2	2	3	4	2	4	2
None	17	57	39	45	22	33	61	40	78	42
Total	30	100	87	100	67	100	154	100	184	100

Table 13: Provider's descriptions of challenges and successes with IUCD service expansion

Challenges in the effort to expand IUCD service	Hospital		Health Centers						Total	
	Count	%	Urban		Rural		HC Total		Count	%
			Count	%	Count	%	Count	%		
No challenge	7	23	13	15	18	27	31	20	38	21
Shortage of supply	2	7	5	6	5	8	10	7	12	7
Not working on FP/Don't know/Don't give the service	0		1	1	2	3	3	2	3	2
Convincing clients	0		1	1	0		1	1	1	
Room scarcity	1	3	0		2	3	2	1	3	2
Women's don't prefer IUCD	0		6	8	2	3	8	5	8	4
Shortage of provider	4	13	2	2	8	12	10	7	14	8
Lack of awareness of knowledge of IUCD	9	30	41	48	16	23	57	36	66	36
Shortage of training for providers	2	7	1	1	5	8	6	4	8	4
Fear of complication/Side effects	0		3	3	2	3	5	3	5	2
Shy to show their body	0		7	8	2	3	9	6	9	5
Fear of their husband	0		2	2	4	6	6	4	6	3
Shortage of transport	0		2	2	1	1	3	2	3	2
Small no of users	1	3	2	2	0		2	1	3	2
No supporting partner	0		1	1	0		1	1	1	
Clients ask for removal with in short time	2	7	0		0		0		2	1
Being pregnant while using IUCD	2	7	0		0		0		2	1
Total	30	100	87	100	67	100	154	100	184	100
Successful efforts described to expand IUCD service?										
Supportive supervision should be encouraged	1	3	3	3	1	1	4	3	5	3
Creating awareness among the community	5	16	18	20	20	30	38	25	43	23
Working hard on FP service/Expanding the service	2	7	8	9	2	3	10	7	12	6
Awarding role models	1	3	5	6	1	1	6	4	7	4
Increasing No of users	8	27	7	8	5	8	12	8	20	11
Collaboration with other service sectors	0		1	1	4	6	5	2	5	3
Counseling/Health education	6	20	10	12	10	15	20	13	26	14
Trained man power/Adequate supply	2	7	10	12	11	16	21	14	23	13
There is improvement	0		5	6	3	4	8	5	8	4
No problem	5	17	17	19	5	8	22	14	27	15
Providing good service	0		3	4	5	8	8	5	8	4
Total	30	100	87	100	67	100	154	100	184	100

Table 14: Demographic characteristics of female health facility clients

% distribution of respondents by region	Hospital		Health Centers						Total	
	Count	%	Urban		Rural		HC Total		Count	%
			Count	%	Count	%	Count	%		
Tigray	20	11	20	5	80	13	100	10	120	10
Amhara	10	6	58	16	177	28	235	23	245	20
Oromia	50	28	100	27	180	28	280	28	330	28
SNNP	40	22	20	5	200	31	220	22	260	22
Addis Ababa	50	28	111	30	0		111	11	161	14
Dire Dawa	10	6	60	17	0		60	6	70	6
Total	180	100	369	100	637	100	1006	100	1186	100
% distribution of respondents by marital status										
Single	33	18	50	14	45	7	95	9	128	11
Married	137	76	297	80	548	86	845	84	982	83
Divorced / Separated / Widowed	10	6	22	6	44	7	66	7	76	6
Total	180	100	369	100	637	100	1006	100	1186	100
% distribution of respondents by age category										
Age 15 to 20	33	19	67	18	129	20	196	20	229	19
Age 21 to 30	103	57	200	54	356	56	556	55	659	56
Age 31 to 40	40	22	95	26	126	20	221	22	261	22
Age 41 to 49	4	2	7	2	26	4	33	3	37	3
Total	180	100	369	100	637	100	1006	100	1186	100
Respondent Age(Mean)	27		27		27		27		27	
Respondent Age(Median)	26		27		26		26		26	
% distribution of respondents by religion										
Orthodox	109	61	220	59	292	45	512	51	621	52
Muslim	19	10	81	22	123	19	204	20	223	19
Protestant	49	27	60	16	217	34	277	27	326	27
Catholic	3	2	6	2	3	1	9	1	12	1
Traditional	0	0	2	1	2	1	4	1	4	1
Total	180	100	369	100	637	100	1006	100	1186	100
% distribution of respondents by education										
No schooling	29	16	110	30	307	48	417	41	446	37
Can read and write but no formal education	1	1	1	1	2	1	3	1	4	1
Primary	65	36	133	36	220	34	353	35	418	35
Secondary or higher	85	47	125	33	108	17	233	23	318	27
Total	180	100	369	100	637	100	1006	100	1186	100

Table 15: Health facility client's knowledge of and use of FP methods

Type of FP methods known	Hospital		Health Centers						Total	
	Count	%	Urban		Rural		HC Total		Count	%
			Count	%	Count	%	Count	%		
None	6	3	29	5	7	2	36	4	42	4
IUCD/loop	143	79	318	50	255	69	573	57	716	60
Oral Contraceptive pills	163	91	527	83	330	89	857	85	1020	86
Injectable	167	93	594	93	349	95	943	94	1110	94
Implants	141	78	504	79	302	82	806	80	947	80
Condom	77	43	171	27	135	37	306	30	383	32
Emergency contraception	18	10	29	5	35	10	64	6	82	7
Other ...	3	2	14	2	8	2	22	2	25	2
Total	180	NA	637	NA	369	NA	1006	NA	1186	NA
Types of methods ever used by women's										
None	42	24	162	27	80	22	242	25	284	25
IUCD/Loop	10	6	18	3	19	5	37	4	47	4
Oral Contraceptive pills	60	33	154	24	118	32	272	27	332	28
Injectable	99	55	377	59	238	65	615	61	714	60
Implants	26	14	120	19	41	11	161	16	187	16
Condoms	20	11	10	2	19	5	29	3	49	4
Emergency contraception	5	3	1		4	1	5	1	10	1
Other method	0	0	0		1		1	0	1	0
Total	180	NA	637	NA	369	NA	1006	NA	1186	NA
Types of methods currently used by women's										
None	64	48	146	33	119	42	265	36	329	38
IUCD/Loop	4	3	13	3	13	5	26	4	30	4
Oral pills	11	8	17	4	19	7	36	5	47	6
Injectable	29	22	189	42	89	32	278	38	307	36
Implants	19	14	77	17	33	12	110	15	129	15
Condoms	5	4	2	1	9	3	11	2	16	2
Emergency contraception	0		1		0		1		1	
Other	1	1	1		1	1	2		3	
Total	132	NA	446	NA	282	NA	728	NA	860	NA

Table 16: Health facility client's reasons for non-use of modern family planning methods

Types of reasons for not using modern FP method's	Hospital		Health Centers						Total	
	Count	%	Urban		Rural		HC Total		Count	%
			Count	%	Count	%	Count	%		
Fear of side effects	9	9	29	9	13	7	42	8	51	8
Fear of infertility	2	2	5	2	3	2	8	2	10	2
Don't know where to get	0		3	1	0		3	1	3	1
Have medical contradictions	1	1	2	1	1	1	3	1	4	1
Don't like modern methods	3	3	9	3	8	4	17	3	20	3
Declared infecund/infertile	3	3	3	1	1	1	4	1	7	1
Not allowed in my region	1	1	4	1	2	1	6	1	7	1
Disapproval of my husband	1	1	4	1	5	3	9	2	10	2
Want to get pregnant	17	16	90	29	49	25	139	27	156	25
Don't have a partner/husband currently	34	32	141	46	66	33	207	41	241	39
Currently pregnant	22	21	47	15	38	19	85	17	107	17
Gave birth recently and lactating mother	20	19	25	8	36	18	61	12	81	13
Not practicing sexual intercourse	11	10	16	5	21	11	37	7	48	8
Using other FP methods	7	7	14	5	11	6	25	5	32	5
Almost out of pregnancy age	4	4	16	5	11	6	27	5	31	5
Not comfortable to use it	0	0	10	3	2	1	12	2	12	2
Don't have menstrual cycle currently	2	2	6	2	3	2	9	2	11	2
Due to sickness	1	1	8	3	1	1	9	2	10	2
Don't know	1	1	13	4	2	1	15	3	16	3
Other	2	2	19	6	6	3	25	5	27	4
Total	106	NA	308	NA	199	NA	507	NA	613	NA

Others include: Just married (6), Did not plan to use it (4), Faced unexpected pregnancy when using (4), Planned to use it now (3), Family planning needs good foods (3), Contraindications (2), Service problem (2), FP method appointment reached (2), Need to discuss with my husband (1)

Table 17: Health facility client's IUCD use status and source of information

IUCD use status	Hospital		Health Centers						Total	
	Count	%	Urban		Rural		HC Total		Count	%
			Count	%	Count	%	Count	%		
Never used IUCD	133	93	234	92	300	94	534	93	667	93
Previously used IUCD, but not currently using	6	4	7	3	5	2	12	2	18	3
Currently using IUCD	4	3	13	5	13	4	26	5	30	4
Total	143	100	255	100	318	100	573	100	716	100
Source of information										
Health facility	89	62	164	64	181	57	345	60	434	61
HEW	20	14	46	18	92	29	138	24	158	22
Friend/relative	36	25	87	34	97	31	184	32	220	31
Radio	57	40	109	43	58	18	167	29	224	31
TV	89	62	147	58	61	19	208	36	297	42
I read about it	7	5	12	5	6	2	18	3	25	4
Community volunteer	1	1	10	4	11	4	21	4	22	3
Other	8	6	16	6	17	5	33	6	41	6
Total	143	NA	255	NA	318	NA	573	NA	716	NA

Table 18: Positive and negative attitudes towards the IUCD

Positive attitudes towards IUCD	Hospital		Health Centers						Total	
	Count	%	Urban		Rural		HC Total		Count	%
			Count	%	Count	%	Count	%		
None	18	13	49	19	115	36	164	29	182	25
Prevents pregnancy for long time	97	68	180	71	138	43	318	56	415	58
Very effective method	40	28	60	24	81	26	141	25	181	25
Low maintenance	19	13	39	15	21	7	60	11	79	11
No hormones(like pills/injectable)	41	29	59	23	22	7	81	14	122	17
Does not affect fertility	55	39	86	34	37	12	123	22	178	25
Cost effective/affordable	1		7	3	1		8	1	9	1
Other	13	9	20	8	22	7	42	7	55	8
Total	143	NA	255	NA	318	NA	573	NA	716	NA
Negative attitudes towards IUCD										
None	88	62	138	54	231	73	369	64	457	64
Increases risk of infertility	13	9	30	12	18	6	48	8	61	9
Increases risk of infection	16	11	30	12	27	8	57	10	73	10
Might fall out after insertion	14	10	28	11	9	3	37	6	51	7
Painful to insert(fear of insert)	4	3	17	7	12	4	19	3	23	3
IUCD will feel uncomfortable	9	6	16	6	21	7	37	6	46	6
partner will feel during sex	8	6	10	4	5	2	15	3	23	3
Too many doctor visits	0		1		0		1		1	
Pelvic exam invasive/embarrassing	0		5	2	1		6	1	6	1
Baby can be born with IUCD in body	2	1	8	3	0		8	1	10	1
IUCD will move to other parts	10	7	17	7	10	3	27	5	37	5
Other	15	10	44	17	28	9	72	13	87	12
Total	143	NA	255	NA	318	NA	573	NA	716	NA
Women's partner should approve before she use IUCD										
Yes	134	94	242	95	282	89	524	92	658	92
No	9	6	13	5	36	11	49	8	58	8
Total	143	100	255	100	318	100	573	100	716	100

Table 19: Health issues attributed to IUCD use and client satisfaction

Health issue experience	Hospital		Health Centers						Total	
	Count	%	Urban		Rural		HC Total		Count	%
			Count	%	Count	%	Count	%		
Don't experience health issues	2	50	9	69	9	69	18	69	20	67
Heavy bleeding	0		2	15	2	15	4	15	4	13
Abdominal pain	1	25	0		2	15	2	8	3	10
Infections	1	25	0		0		0		1	3
Expulsions	1	25	0		1	8	1	4	2	7
Other	0		3	23	2	15	5	19	5	17
Total	4	100	13	100	13	100	26	100	30	100
Others include: menstrual cycle delay, pain during sex, joint pain, pain during urination, uncomfortable IUCD										
Satisfied with the health provider.										
Yes	4	100	13	100	12	92	25	96	29	97
No	0		0		1	8	1	4	1	3
Total	4	100	13	100	13	100	26	100	30	100

Appendix I. Specific objectives of the evaluation plan

- Determine the availability (number) of providers trained on IUCD service provision in selected facilities
- Identify provider's knowledge and attitudes towards IUCD
- Determine availability of supplies, commodities and equipment for IUCD service provision at service delivery points
- Determine uptake of IUCD service at facility level and access to IUCD removals
- Describe women's knowledge of, attitudes towards and practice with the IUCD
- Document/describe the support and commitments that the Regional Health Bureaus (RHBs), zonal and woreda health offices have made towards IUCD scale-up
- Determine what demand creation activities have been implemented thus far
- Identify successes and challenges in IUCD service expansion

