

Evaluation of permanent family planning method services in selected health facilities in Ethiopia

March 2015

Family Health International 360 (FHI 360)

Background

A mini-assessment was conducted to investigate the current state of permanent family planning methods, specifically bilateral tubal ligations (BTLs) and non-scalp vasectomies (NSVs), in selected health facilities across several regions in Ethiopia. The aim of the assessment was to determine whether the services are being delivered at the different health facilities by the trained staff.

The selected health facilities were those that had a few of their staff receive BTL and NSV trainings recently. The list of the trained staff and their place of work was provided to FHI 360 by the FMOH’s MCH directorate. The list included the names and phone numbers of trained staff. We contacted those on the list using their mobile number to schedule an interview.

While most of those on the list were not in the facilities that they were associated with in the given list, we were able to interview 42 participants-- 36 of them interviewed in person and 6 interviewed over the phone. Of the 17 health facilities on the list, FHI 360 visited 13 of the facilities while information for an additional 4 sites was collected over the phone. We also visited 3 health facilities that were not on the list but that the trained staff had moved to after receiving the training – in total we visited 16 health facilities.

A structured survey questionnaire was developed covering five areas: Background, Quality of the PM Trainings, Provider Experience, Material Check, and Challenges. The main findings of the assessment are summarized below.

Results

1. Data Collected from trained providers

As shown in Figures 1 and 2, respondents were satisfied with the overall quality of the theoretical training as well as the practical attachment.

Figure 1: Respondents overall rating of the permanent method training received (percent)

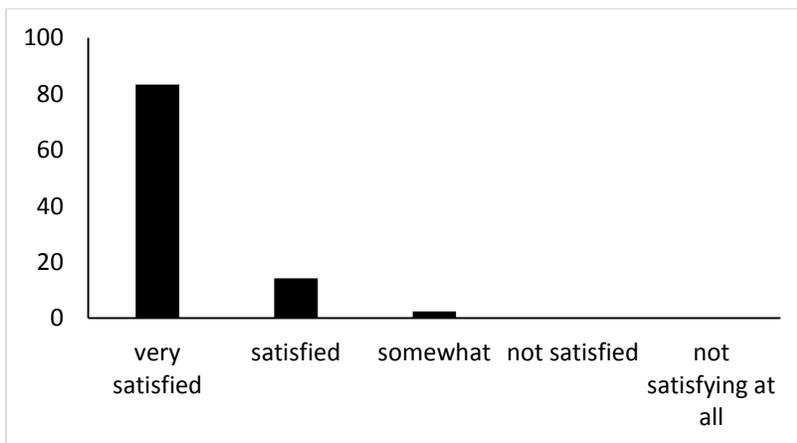
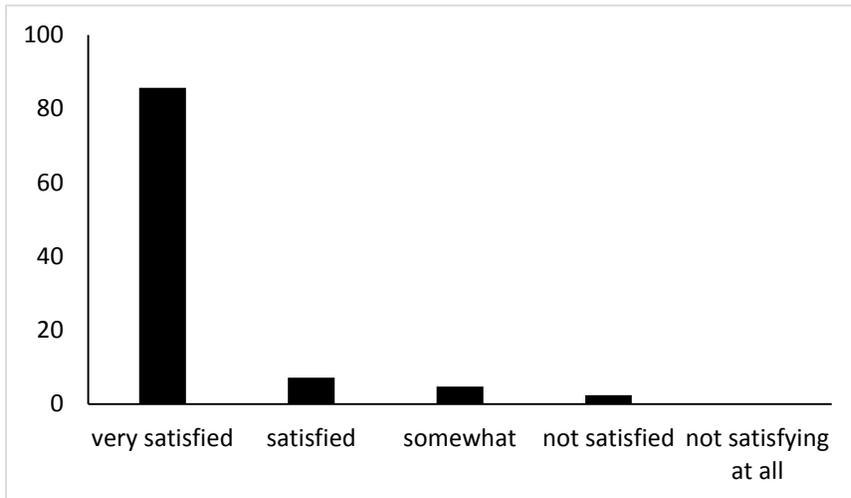


Figure 2: Respondents rating of the practical attachment portion of the training (percent)



While most participants have performed several bilateral tubal ligation during their practical attachment, only very few performed non-scalp vasectomies (NSV) during the practical attachment. **On average trainees performed 16.98** bilateral tubal ligations during their practical attachment. However, trainees had only performed an **average of 1.17 NSVs** during their practical attachment (see Figure 3 and 4).

Figure 3: Number of BTLs performed during the practical attachment

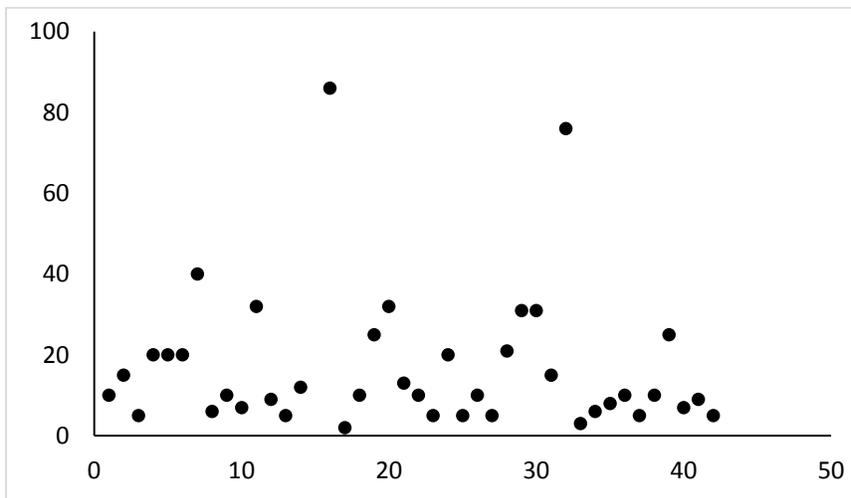
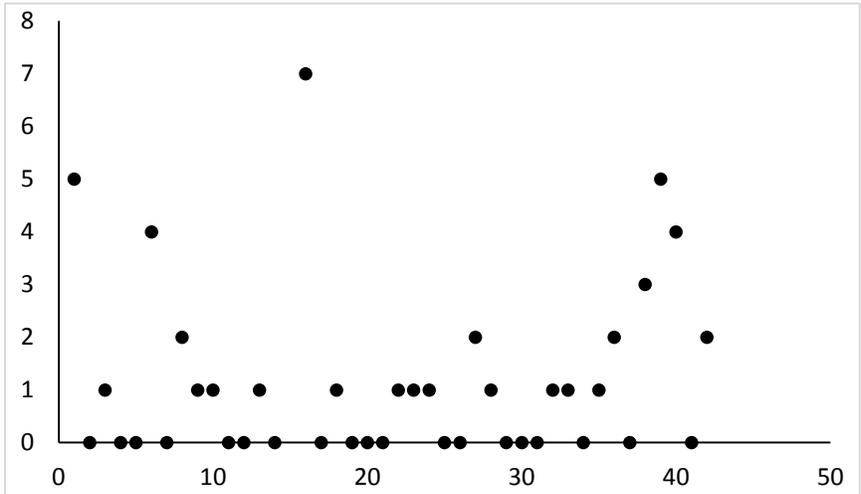


Figure 4: Number of NSVs performed during the practical attachment



When we look at how many BTLs and NSVs the providers had conducted in a specific time frame of 6 months (July to December 2014), **on average the respondents had performed 8.78 BTLs and only 0.32 NSVs in the 6 months before the survey.** Looking at the distribution (see Figure 5 and 6), over half of the providers have not performed any BTLs in the time period and only 5 of the respondents had performed an NSV. Upon further examination, some of these NSVs and BTLs were part of campaigns that were part of trainings provided by partners (e.g., Engender Health).

Figure 5: Number of BTLs performed from July 2014 to December 2014

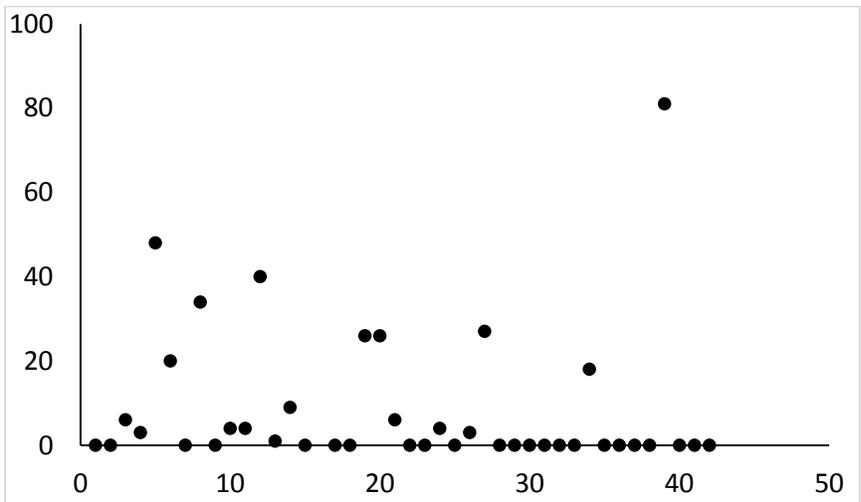
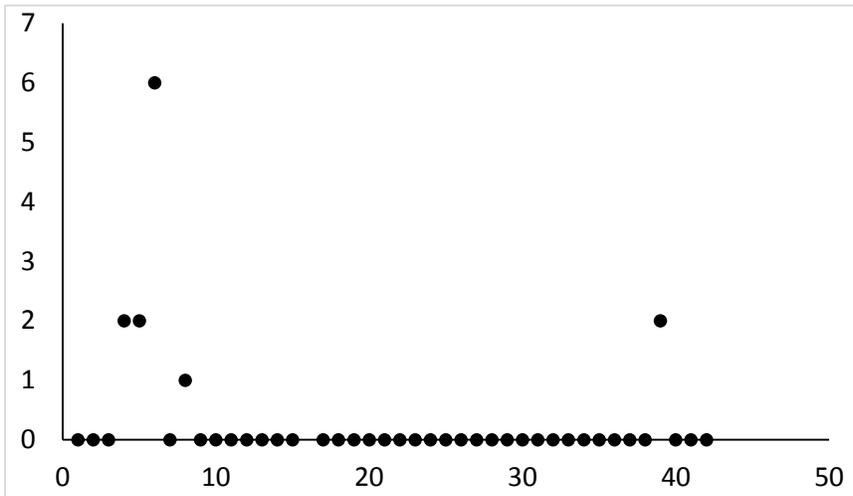


Figure 6: Number of NSVs performed from July 2014 to December 2014



In total respondents reported that they had performed an average of **1.76 NSVs and 39.57 BTLs** since receiving the PM training (which ranged 1 to 4 years back).

Figure 7: Number of BTLs performed since the training

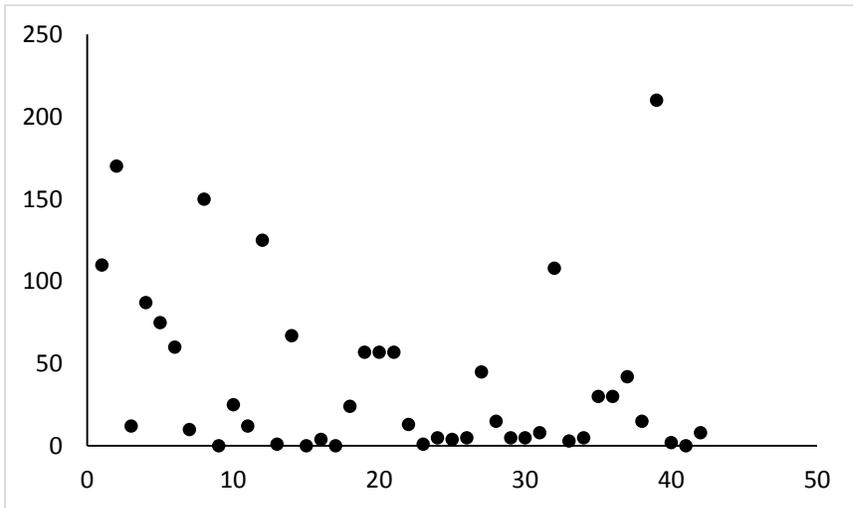
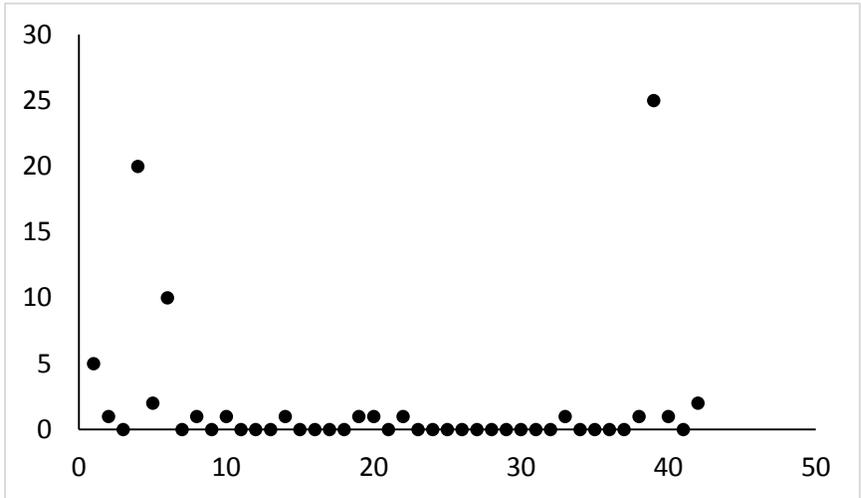


Figure 8: Number of NSVs performed since the training



Facility data complemented these self-reports with only very few facilities reporting any NSVs while BTLs were more distributed among the facilities.

Figure 9: Number of NSVs performed at the health facility from July 2014 to December 2014

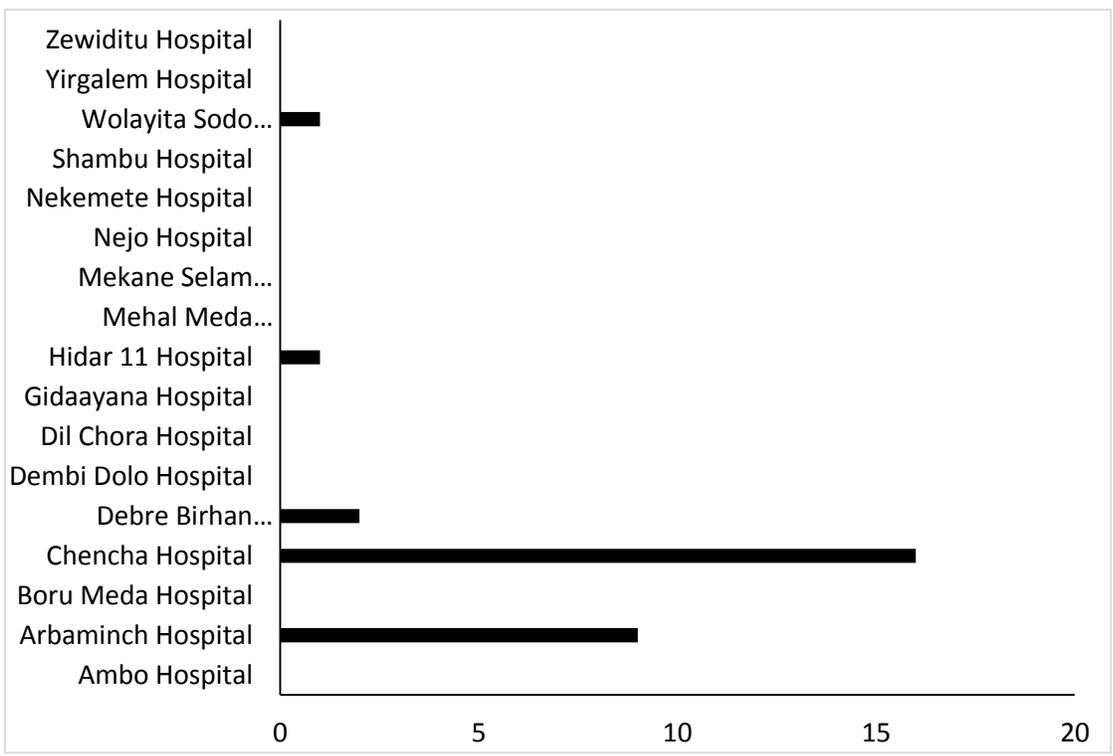
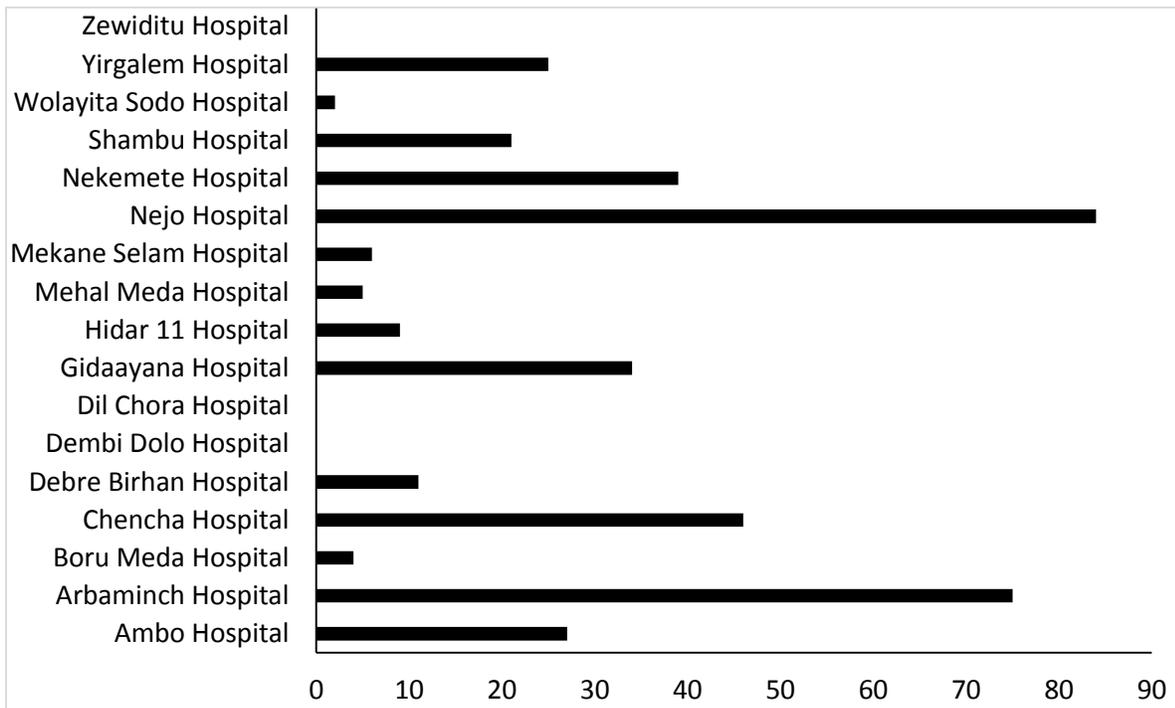


Figure 10: Number of BTLs performed at the health facility from July 2014 to December 2014



These low numbers were surprising given the self-reported high levels of interest in providing the services – **93 percent of respondents said they were interested in providing BTL and NSV services.** However, respondents felt more competent in providing BTL services than NSVs--**92.9 percent said they were ‘Very competent’ or ‘competent’ providing BTL services while only 66.6 percent** said the same about NSVs.

Figure 11: Self-rating of interest to providing NSVs and BTLs

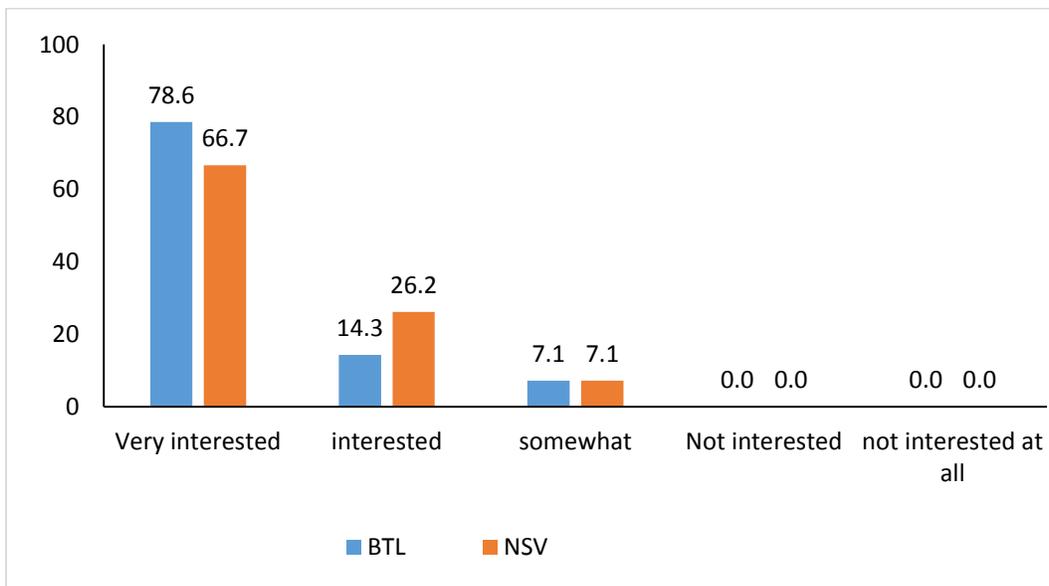
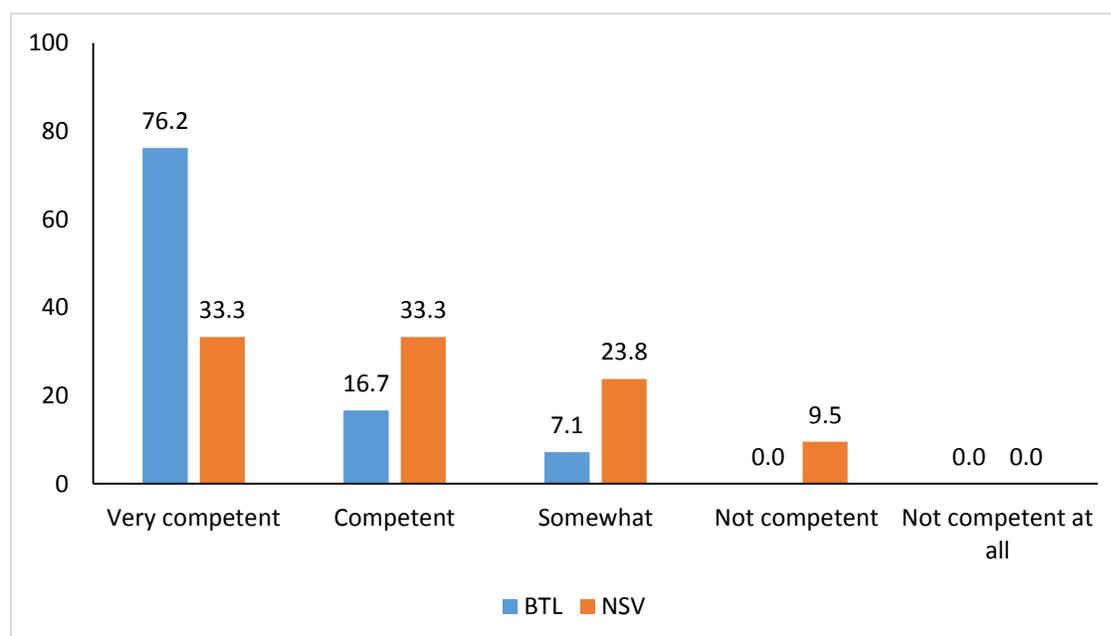


Figure 12: Self-rating of competence to providing NSVs and BTLs



Some of the challenges reported by the respondents are shown below in Table 1.

Table 1: Respondents identified challenges to scaling up permanent methods in Ethiopia

Supply-side problems	Percent
Inadequate equipment, human resource and training	81.0
Lack of commitment from government and/or provider	16.7
Weak community mobilization by HEW/HCs	21.4
Weak coordination and referral links between HP-HC-Hospitals	14.3
Lack of incentive for providers	7.1
Demand-side problems	
Lack of awareness about BTLs and NSVs among the community	50.0
High cost of transportation to service site	7.1
Fear of pain	2.4
Cost associated with service (e.g., cost of Antibiotics)	4.8
Client expectation for compensation	2.4

2. Data Collected from partners (Engender, IPAS, & Pathfinder)

IPAS, Engender Health, FGAE, and Pathfinder were contacted for this survey. While IPAS and Engender Health have indicated they have provided training during July to December 2014, FGAE has not been providing those training during the mentioned period. Pathfinder has informed us that they do not provide FP trainings.

Table 2: Number of individuals trained by Engender Health and IPAS from July 2014 to Dec 2014

Types of trainings	Oromia	Amhara	Tigray	SNNP	BSG	Gambella	Somali	Afar	Harari	DD	AA	Total
Comprehensive FP training	88	130	10	91	1	0	0	0	0	0	55	375
PM FP Methods training (NSVs& BTLs)	21	6	0	10	0	0	0	0	0	0	0	37

In general, in the six months period from July to December of 2014, Engender and IPAS reported having trained 375 individuals on the Comprehensive FP Training, and 37 on Permanent Methods Training (Vasectomy & Tubal Ligation) spread across Oromia, Amhara, Tigray, SNNP and Addis Ababa. Of those who have been trained, the partners felt that only 'some' are using their training and providing the service. This is despite partners (Engender and IPAS) making available necessary equipment for BTLs and NSVs in the health facilities after the training.

When asked about the main challenges faced in providing FP methods training, the following were mentioned: poor internal and external referral system, poor facility setting to provide the service, community mobilization problem, lack of necessary follow ups from managers and leaders, and rotation of trained staff to other activities.

When asked to mention best practices that the FMOH and other partners need to know when considering the implementation of permanent FP methods in Ethiopia, the following were mentioned most often:

- Linking the PM FP initiative with HEW and HDA
- Avoiding missed opportunity (e.g., engaging mothers in a discussion about the availability of PM to be conducted immediate after delivery/caesarian section)
- Ensuring the trainings are strictly following the national guideline
- Checking the competence of trained staff after 4-6 weeks of the training

When asked to recommend ways to increase acceptors of permanent FP methods in Ethiopia, the following were mentioned:

- Advocacy and BCC work should be done at large for the community
- Enhance the referral system, providing the training to HEW in order to increase the acceptor
- Establish mobile clinics
- Avail proper setting
- Male involvement should be considered
- Ensure clients receive adequate counseling

Lastly, partners mentioned that including permanent FP method provision as part of the pre-service training for provides will increase the number of qualified providers in Ethiopia

Conclusion and Programmatic Recommendations

This mini-assessment showed that while providers were well trained and willing to provide BTLs, they received less comprehensive training in NSVs and were less comfortable providing NSVs. However, despite the trainings and the provision of materials to conduct NSVs and BTLs by partners, very few BTLs and NSVs have been conducted after the trainings. Trained providers and partners mention two key issues as the limiting factor for the low numbers in PM services: 1) the rotation of trained staff to other units in the health facility (i.e., the lack of a dedicated, trained professional whose main job is working on FP methods), and 2) lack of demand from the community.

These findings suggest the need for assigning a trained dedicated-staff, who will not be rotated to a different unit, to work on providing FP methods in the health facilities. Moreover the findings also show a need for demand creation activities which may include behavioral change communication, proper counseling of clients on all the available FP methods including PM. For information about PM to be included during counseling, BCC materials having clear description of what PMs are and their benefits and consequences needs to be made available to counselors.