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Profile of Clients of Different Providers of Family Planning Services in Egypt

Final Report

Social Planning, Analysis & Administration
Consultants (SPAAC)

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SPAAC STUDY TEAM

Sarah Loza (Ph D)	Principal in Charge
Nazek Nosseir (Ph D)	Principal Investigator
Mounir El-Tawil (MD, D P H)	Co-Principal Investigator
Iman Soliman (M Econ)	Editor & Analysis Coordinator
Mostafa EL-Sayed (B A)	Field Work Organizer
Rosa Abdel Malek (B Comm)	Computer Specialist
Dina S Ahmed (B A)	Research Assistant
Sabah El-Werdany (B Soc W)	Data Processing Supervisor

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Executive Summary

The Government of Egypt launched its national family planning (FP) program in 1966. The early phase of the program was mainly supply oriented and aimed at ensuring wide distribution of contraceptives primarily through pharmacies to meet an anticipated rising demand.

Between 1988 and 1992 a number of additional sources of FP services appeared, with an increase in clinic based services through both the private and public sectors. The market share of commercial pharmacies was reduced during this same period. In 1992 about one fourth of users relied on pharmacies to get their family planning supplies compared to about one half in 1988. This change evolved through the influence of two forces: the first was the initiation of a number of family planning projects, including the Clinical Services Improvement project (CSI), the Health Insurance Organization (HIO) and Teaching Hospital Organization (THO), the second was expanded and improved family planning services in Ministry of Health facilities through USAID funded Systems Development Project (SDP).

Because of these important changes in the service delivery systems, senior program managers required information on the current market segmentation to identify any overlap among activities of various service delivery systems. This study was designed to assess the complementary/competitive roles of these systems. It probes into factors that influence clients' movements from one type of service provision to another, and their experience with services received.

The study was based on a large data set that was collected through exit interviews with nearly 5,000 clients served by various service delivery points. Six governorates were selected and sampled to insure wide geographic coverage as well as inclusion of various socio-demographic and economic segments of the population. The selection of appropriate SDP's in these sampled areas was done purposively.

The findings indicated that, apart from a degree of overlap, the family planning program in Egypt had reasonable market segmentation. Clients of private physicians were more likely to be from the urban, and to less extent rural, upper and upper middle class and visited them mainly seeking obstetric and gynecologic services and FP services when needed. CSI clients tended to be from the upper middle and middle urban classes and some better off rural women who went for FP and other services. EFPA clients were mainly urban middle and lower middle class women who resided mostly in the same locality and sought mainly FP services. Urban lower class women sought FP and pre- and postnatal care at MCH centers. Rural Centers and Units' clients were lower class rural women who were mostly pill users. Hospital clinic clients were urban and rural low income women seeking FP and gynecologic/obstetric services.

Market segmentation was also evident when examining what women were looking for when selecting SDPs. Their primary reason for selecting Rural SDPs was accessibility followed by low primary service cost. The same reasons apply to MCH centers with the addition of competence of service providers. Hospital clients cited appropriateness of cost and competency. EFPA clients cited the three above reasons plus care and respect shown to clients and the presence of female physicians. Private physician (PP) clinic clients' main reasons for selecting a provider were competence of and trust in service providers and respect shown to clients. CSI clients referred to competency to a lesser extent than clients of PP but to a greater extent than other SDP clients. They also referred to care and respect, presence of female physicians and clean, well equipped premises.

Findings of the study indicated that the reasons most frequently mentioned for shifting from pharmacies, rural SDPs, and MCH centers were side effects or complications of the contraceptive method used or 'dissatisfaction with the method' probably reflecting inadequate counselling given by service providers. These reasons were also given by clients who shifted from other types of SDPs, but with less frequency. Inaccessibility of site was the main reason mentioned for leaving CSI clinics, hospitals and to less extent EFPA clinics. High cost was the reason most frequently mentioned for leaving PP clinics.

Clients unprompted knowledge of other SDPs providing FP services was found to be weak. Clients were more likely to know about private physicians, hospital and CSI clinics than other SDPs. Few clients knew about EFPA clinics.

Conforming with other recently available findings, the cost of FP/other service was not viewed as excessive by the majority of clients. However only about 11 and 12% of clients were willing to pay more for FP and other services respectively. Thus significant improvement in the quality of service is needed for better achievement of cost recovery goals.

A large majority (over 98%) of FP clients stated they intend to continue use the SDP at which they were interviewed, with no significant difference by type of SDP. This again confirms that clients have different priorities and needs when seeking service and that the different types of SDPs complement, rather than compete with, each other.

A Study Profile Of Clients Of Different Providers Of Family Planning Services

I Background of the Study

The Government of Egypt (GOE) launched a nationwide family planning (FP) program in 1966 although voluntary family planning efforts in the country extend back to the 1950's. The first phase of the program was clinic based and supply oriented, and aimed at satisfying a demand for family planning through the distribution of contraceptives. However, interest in conditions affecting the demand for services was needed. This interest resulted in a variety of motivation and distribution strategies implemented by the end of the decade. A national program to decentralize population and family planning activities was introduced.

Current family planning efforts in Egypt consist of different modes of service delivery: a clinic-based program (public, private and NGO), a community-based program, a social marketing program, as well as a commercial sector (pharmacies and private physician clinics). Because of the diversity and number of service providers, the family planning program is organizationally complex. It consists of public and private efforts and involves government agencies in a variety of roles.

The National Population Council is responsible for policy formulation, planning, coordination, monitoring and evaluation of population and family planning activities in the country. The Ministry of Health (MOH) is responsible for service delivery within the government sector. Private Voluntary Organizations (PVOs) that provide family planning services are members of the Egyptian Family Planning Association (EFPA), is registered under the Ministry of Social Affairs (MOSA).

MOSA also co-administers an initiative project that focuses on quality of service delivery which is the Clinical Services Improvement Project (CSI), an affiliate to the EFPA, in addition to Family of the Future (FOF) activities, also registered under MOSA. The State Information Service (SIS) directed the IEC component of the government program with some assistance from the private sector and the Ministry of Education. Towards the end of 1993 the government appointed a new State Minister for Population and Family Affairs to be responsible for all population and family planning related activities.

The clinic-based program in Egypt maintains an extensive network of family planning/health infrastructure outlets and clinics. MOH provides family planning services through general, specialized and teaching hospitals, maternal and child health centers, rural health centers/units, and polyclinics. Non-governmental voluntary organization clinics include EFPA clinics, CSI clinics, and other voluntary organizations' clinics. Private outlets include clinics of private physicians. In addition a new program has been introduced to motivate junior physicians to start their own private family planning clinics in villages and secondary towns.

The public service delivery sources are non-profit activities, whether provided by the government or voluntary agencies. The private service delivery sources are profit oriented, whether provided by individuals or institutions. A number of non-profit services are totally subsidized by the government or supported by international organizations or by the GOE bilateral agreements.

In such a situation of diversity of service providers the critical question is which clients go where and why? In other words who are the clients served by various family planning providers in Egypt? Why do clients seek out certain types of providers? Why do they avoid others? What is the client's experience/satisfaction/dissatisfaction with the services received from certain providers? What is her perception about service offered at other service delivery points (SDPs)? Do different types of SDPs serve different types of clients i.e. market segmentation, or do SDPs compete for the same clients? Answers to such questions provide an understanding to better segment the market amongst various SDPs in order to avoid unhealthy competition and duplication of efforts.



Objectives of the Study

The objectives of the study are to

- Ascertain the degree to which available family planning services complement and compete with one another
- Provide necessary information to better target family planning services and resource allocation
- Assist in establishing policies related to cost recovery of family planning services

To achieve these objectives, the research was designed to

- Identify the clients of different service providers and examine the issues they look for when selecting a service source
- Measure the clients' knowledge and attitudes about other family planning sources
- Examine clients' motives for switching service sources
- Identify what and/or who motivates clients to seek change, or remain with service source
- Explore clients' opinions about cost of supplies and related services



Methodology

A SAMPLING

A sample survey using a national sample from both rural and urban regions was designed and carried out. A multi-stage sampling design was used to sample current and former clients of different service points. In the first stage, governorates were sampled, followed by districts or kisms, then service points, and finally clients were interviewed.

1 Sampling Governorates

Estimates for developmental and demographic indicators were provided for the main three divisions in Egypt Urban, Lower and Upper Egypt governorates. The selected samples represented the entire country with the exception of the Frontier Governorates.

Some socioeconomic and reproductive indicators were developed for each governorate within the three divisions mentioned above. The source of data was the 1986 Population and Housing Census, the annual Vital Statistics and the Demographic and Health Survey of 1988 (the most recent DHS at the time of the research design). These indicators reflected the socioeconomic status of each governorate.

For comparison, the distribution of the governorates within each division, according to each indicator was converted into standardized values or scores. The method for standardizing consisted of calculating the mean values and the standard deviation of governorates' scores on each indicator. The mean value was then taken as the zero value for each indicator and the distance of any given raw score from the mean was measured in terms of standard deviation units (plus or minus). Thus all scores were converted into positive or negative multipliers of the standard deviation. The relative standing of each governorate, measured by units of standard deviation, according to each indicator was averaged into degree of socioeconomic development.

Using this index the governorates within each division were classified into two groups: the more developed and the less developed. One governorate was then selected randomly from each group within each division, resulting in six governorates: two Urban, two from Lower Egypt, and two from Upper Egypt.

2 Sampling Districts Within Each Governorate

Given the six sampled governorates, a number of districts/kisms were randomly selected.

From the Urban Governorates

Kisms which have more than one type of service provider (mainly CSI, EFPA, and MCH centers) were screened and two kisms were drawn randomly from them. If any kism did not fulfill the requirements of

representing all types of service providers, the missing service providers were obtained from the nearest kisms

From the Rural Governorates

The capital district was selected, and then three districts were drawn randomly. Each district consisted of a city and a number of villages. Districts that were included in the sampling frame had to have a complete mix of all types of service providers.

3. Selecting Service Delivery Points (SDPs)

From the six governorates, a total sample of 216 SDPs were selected from within 20 districts/kisms in the six governorates.

From the Urban Governorates

In each kism, the SDPs included consisted of

- One general or teaching hospital (MOH secondary health service facility with FP related services)
- One maternal and child care clinic (MOH primary health facility with FP related services)
- One CSI clinic (special FP service project under EFPA regulated by MOSA)
- One FPA clinic (PVO FP clinic under EFPA regulated by MOSA)
- Six private physicians' clinics (With up to 50% affiliated to Private Physicians Family Planning Project -- PPFPP -- if possible)

A total of twenty SDPs were selected in each governorate. If any sampled district had more than one unit of any type, a unit was drawn randomly. In the sampling of private physician clinics, a certain proportion of PPFPP physicians was to be included and the sampling frame was to be developed during the field operation.

From the Rural Governorates

The following SDPs were selected from each of the four districts in each governorates

- One MOH general, specialized, or teaching hospital
- One maternal and child health center
- One CSI clinic
- One FPA clinic
- Two rural health centers
- Two rural health units
- Six private physicians' clinics were drawn in the capital district either urban or rural
- Two private physicians' clinics in each of the other districts either urban or rural

A total of 44 SDPs were selected in each governorate. One or two village councils (an administrative division of a mother village and some satellite villages) were randomly selected. A list of all rural health centers/units was compiled for random selection of these types.

4 Sampling Clients

At each of the 216 SDPs an average of twenty clients¹ were interviewed. An interviewer was assigned for each SDP for up to five working days. The first client attending the clinic in each of the working half hour of the clinic was selected for interviewing. The interviewed clients were those who went to the clinic for family planning related services, whether they were new visitors or return visitors on the day of the interview (visitors were women who came to the clinic for family planning related services). The interview was carried out on site, at the exit point.

¹ This average ranged between 15-25 clients. The field supervisor had to get an estimate on the daily case load at each SDP before deciding the number of clients to be interviewed. When the lower limit at each SDP could not be achieved, a sample of clients who had been to the clinic during the week prior to the first day of the interviewing was drawn randomly. A home visit was made to those clients.

A list of the drop-out clients, i.e. the SDP's previous clients who have not visited the SDP for up to three months prior to the first date of the interview, was prepared by the field supervisor from the clinic records when available, and three clients were drawn by systematic random sampling and interviewed in their homes

-
- *Total number of sampled government were 6*
 - *Two Kisms in urban governorate and four districts in rural governorates were selected*
 - *SDP were chosen for this study*
 - *about 4710 women were interviewed*
-

B DATA COLLECTION INSTRUMENT

The data was collected by using a structured interview schedule administered in the six governorates of Cairo, Alexandria, Gharbia, Sharqia, Giza and Minia during the period of May -August 1993. The schedule that was designed for this study provided the following information:

Socio-economic & Demographic Data

- Age of client and her husband in completed years
- Education of client and her husband
- Urban/rural background of client and her husband
- Current place of residence
- Current economic activity of client and her husband
- Monthly family income in broad categories
- Monthly family expenditures
- Housing conditions
- Ownership of durable consumer goods
- Age at first/current marriage
- Number of pregnancies
- Number of children ever born
- Number of living children by sex
- Desire to have more children in the future
- Preferred interval after which next child is desired
- Current pregnancy status

Data on Current SDP

- Source of information and motivation for getting service from this SDP
- Means of transportation used to get to SDP and the cost incurred both in time and money
- How was she met at SDP and the duration of time spent there
- Reason for her visit and whether it is her first visit to the site
- Cost of the service and whether she is willing to pay more
- If client had been there before, when did she first come to this SDP
- FP method used and how it was chosen
- Instructions given regarding possible side-effects, follow up visit, etc
- The client's opinion regarding service at this SDP and main reasons for selecting this SDP

Knowledge and Use of Other SDPs

- Other SDPs client knows
- Other SDPs client used for FP services
- History of shifts among the different SDPs and main reasons
- Contraceptive use during the open birth interval and last closed birth interval
- Current use of contraceptives and intention to continue use

D DATA PROCESSING

1 Data Review and Coding

The review operations began in the field when the data controllers scrutinized the completed questionnaires. This was followed by a 100 percent office review which entailed verification of the answers to all questions and to certain combinations of questions. For the open-ended questions, a code-book was developed for coding and all questions were edge-coded.

2 Data Entry and Data Processing

EPI Info, Version 5.01 is the software that was used for data entry. The data entry program structure was developed with internal checks for wild codes, as well as a number of consistency checks. Frequencies for each governorate were processed after data entry completion, and were reviewed to ensure data quality.

Another data entry program structure was developed and used for dropout cases which totalled 306 cases. In data processing, new database files were created to allow the writing of programs needed for the data analysis using both EPI and SPSS/PC+ in accordance with the plan of analysis.

IV Results and Findings

A INTRODUCTION

A total of 4710 clients (including the drop out clients) were interviewed of which about 83 percent were interviewed upon their exit from the clinic and about 11 percent were interviewed at home, while 6.5 percent were drop outs. As is indicated in Table 1 (all tables are gathered in Appendix I) in the urban governorates only two clients were interviewed at home, mainly because the required sample size was satisfied at the selected sites. In the governorates few drop outs were reached for interviewing, mainly due to the difficulty of identifying addresses in some districts of the metropolitan areas.

In each of those governorates according to the sampling design, a variety of SDPs were selected as sites where clients were interviewed. Table 2 shows the distribution of the clients according to the type of the SDP in the different governorates. In the following presentation and discussion of findings, clients of general, teaching, and university hospitals were grouped together and called 'hospital' clients. Similarly, clients from rural health centers and units were grouped together and referred to as 'rural' clients.

Clients of private physicians were interviewed in 81 clinics in all six governorates.

B DISTRIBUTION OF CLIENTS ACCORDING TO REASON OF VISIT

Clients -- other than the drop outs -- are identified according to whether this is their first visit to the site or they have been there before. More than four clients in every five (78%) have visited the clinic before, while 22 percent are there for the first time, indicating the tendency of clients to return to SDPs where they are comfortable. Clients are asked whether they have come for family planning services or for other services. Table 3 shows that more than half of the first time visitors are there for family planning services while nearly

two thirds of the repeat visitors are there for the same reason. However, these proportions vary widely among the different SDPs.

A significantly higher proportion of clients of all MCH centers, rural centers/units, EFPA, CSI, and hospitals (86%, 82.4%, 78.1%, 74%, and 68% respectively) have come for FP services as compared with only 17.9 percent of clients of private physicians. Clients of private physicians are primarily seeking other services such as pregnancy monitoring, gynecological treatment and/or sterility treatment, as explained below. Figure 1 illustrates the distribution of all clients by the reason for the visit.

Figure 1 CLIENTS BY SERVICE RECEIVED

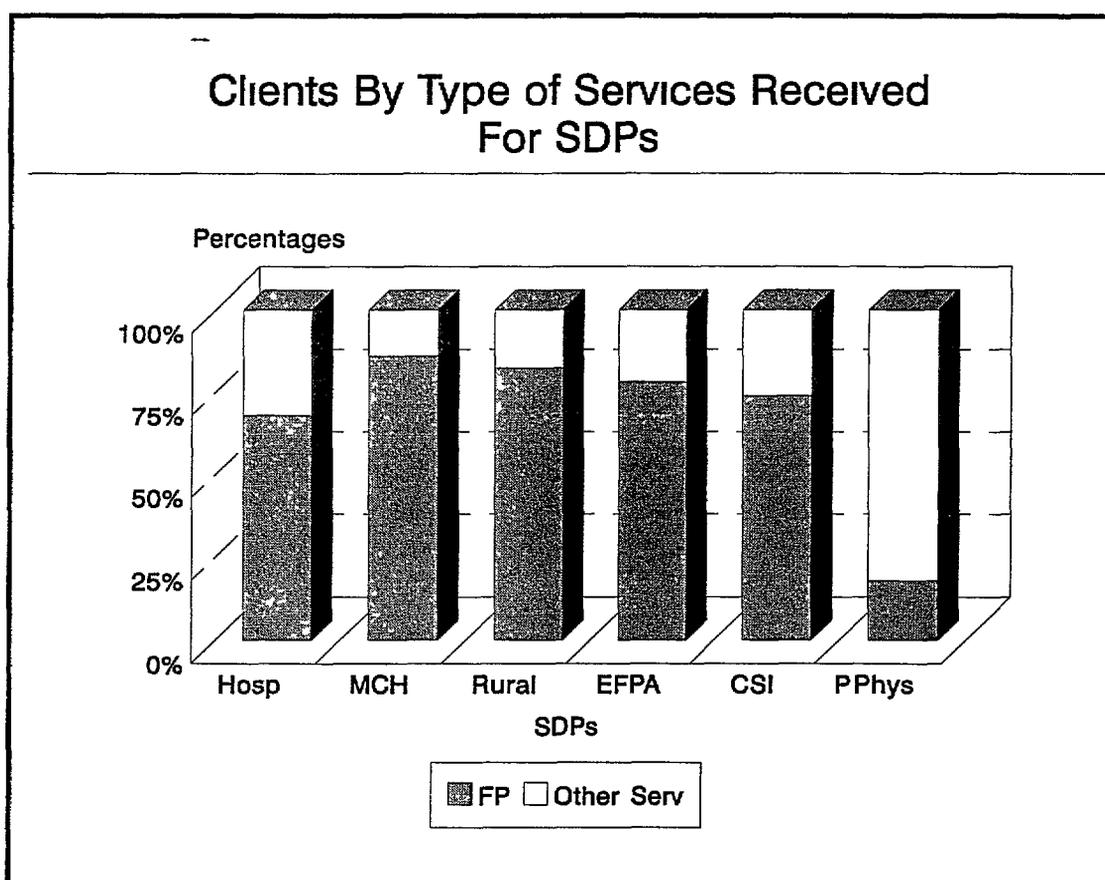


Table 4 shows that more than half of the first time visitors seeking family planning services (54.1%) had an IUD inserted on that day. Most of these are among MCH center and hospital clients.

Table 5 shows first time visitors seeking other services by the service they have received. While one third received pregnancy monitoring and related

services (33.9%), one out of every eight clients requested sterility treatment (12.8%). More than three out of every ten went for gynecological examination (30.9%), and about one in five needed laboratory investigation or gynecological treatment (22.4%). Although this was the overall picture for all SDPs there are major variations among clients of different SDPs with respect to the type of service obtained. Three out of five clients of rural centers/units and MCH centers have gone for pregnancy monitoring (59.3% and 58.8% respectively). Half of the EFPA clients wanted gynecological examinations and almost two out of five (39.2%) of the hospital clients also wanted an exam and (29.2%) have gone seeking gynecological treatment. CSI clients mainly have gone for pregnancy monitoring (35.1%) or laboratory investigation (29.7%). One third of the clients of private physicians have gone for pregnancy monitoring (32.7%), and another one third have gone seeking gynecological examination.

Repeat visit clients who have gone for family planning services have been getting services at the respective SDPs for extended periods of time, as shown in Table 6. Clients of rural centers/units have first gone to the site on average almost four and a half years earlier (53.7 months) while EFPA clients have gone there for the first time four years earlier (48.2 months). In contrast CSI clients have gone there on average sixteen months earlier. This relatively short period for CSI clients is probably due to the recent establishment of these clinics.

As to the type of service obtained by this group of clients, more than one third (34.9%) have gone for IUD follow up and another one third for pill supply (34.0%). More than one in every five has gone for other reasons. IUD

-
- *More than half of the first time visitors seeking family planning services had an IUD inserted on that day*
 - *Almost half of the repeat visit (non-family planning clients) have gone for pregnancy monitoring*
-

insertions (15.3%), periodic contraceptive injection (5.0%), resupply of other contraceptives (1.8%) such as condoms and foam tablets. Another nine percent have gone for other related services such as removal or insertion an IUD but did not get it that day, or to get treatment for some side effects. The majority of private physician clients and CSI clients have gone for IUD follow-up (53.1% and 52.0% respectively). Large proportions of EFPA, MCH center and hospital clients have gone also for IUD follow-up (43.3%, 42.6% and 40.3% respectively). The largest proportion of rural centers/units' clients have gone for pill supply (62.2%).

As with the first time visit clients, (45.7%) have gone for pregnancy monitoring (Table 7). This proportion is higher among the clients of rural centers/units (60.7%), MCH centers (58.5%) and private physicians (51.6%). Additionally, about one fourth of this category of clients (24.1%) have gone for gynecological examination and related services such as examination before marriage and early detection examination. For this category of service, the proportion is more pronounced among the hospital (46.6%) and EFPA clients (31.4%).

Other gynecological treatment is the service received by over one third of EFPA clients (34.4%) and by 31.2 percent of hospital clients. On average, each of these clients has sought service in the respective SDP for over two years (average 27.1 months since first visit). Hospital clients began seeking service there four years earlier on average (48.6 months), while CSI clients began there over one year earlier (12.8 months).

It is interesting to note that, with the exception of hospital repeat visit clients, family planning clients of all other SDPs have a longer average time since first visit than other non-family planning service clients. So the tendency to 'shop around' may be greater for women seeking obstetric and gynecological services than for those seeking family planning services.

C SOURCES OF INFORMATION AND MOTIVATION TO USE SDP

Clients are asked how they learned about the respective SDP. Almost two thirds of all clients say they knew of it through a neighbor, friend, relative or other acquaintances (64.5%). This percentage is higher (76.8%) among clients of private physicians and MCH centers (75.5%). It is considerably lower among the clients of rural health centers/units and centers and CSI clinics (49.7% and 47.8% respectively). Among CSI clients, one in every five has learned about it through billboards, ads and leaflets (Table 8).

The nurse/midwife or social worker is the source of information mentioned by 17.5 percent of the rural centers/units' clients. Another relatively large proportion of rural centers/units' clients cannot single out a source from which they learned about the rural center/unit and say they know of it because it is close to where they live (14.0%). Among the clients of the CSI, more than one in every eight says she knows about it from the nurse/midwife or social worker while 11 percent say that the raída/health visitor is their source of information.

Clients are further asked if they have been motivated or encouraged by someone to go to the respective SDP for service (Table 9). About 58 percent say yes, and once more the large majority specify a neighbor, friend, relative or an acquaintance as someone that has encouraged them to go to the respective SDP. It is evident that personal communication is a powerful and effective source of information and motivation. The nurse/midwife has been influential in encouraging 30 percent of the clients of rural centers/units and 10.2 percent of hospital clients. Relatively large proportions of the clients of private physicians, hospitals and rural centers/units have mentioned that they were encouraged by their husbands (14.8%, 12.2%, and 11.9% respectively).

D REASONS FOR SELECTING THE SDP

Clients are asked to specify up to five reasons as to why they selected the respective SDP. On average each client gives more than three reasons. These reasons are cumulated and analyzed collectively.

Table 10 shows the eight different reasons most frequently cited by the total sample. Each of these reasons is given by at least ten percent of all clients - though lower proportions of clients of particular SDPs may have given it. Five of these reasons have to do with the service providers.

- Competency of service providers (59.3%)
- Care, respect and good treatment by service providers (38.0%)
- Trust in the service providers (34.7%)
- Presence of female doctor (23.3%)
- Having a good followup system (10.0%)

With the exception of the presence of a female doctor, higher proportions of clients of private physicians and CSI clients mention these reasons. To some extent this is expected since private physician clients pay for the quality of the service. Presence of a female doctor is mentioned by more of MCH center and EFPA clients. It is worth noting that reasons relating to the quality of the service providers are not as frequently mentioned by rural center/unit clients.

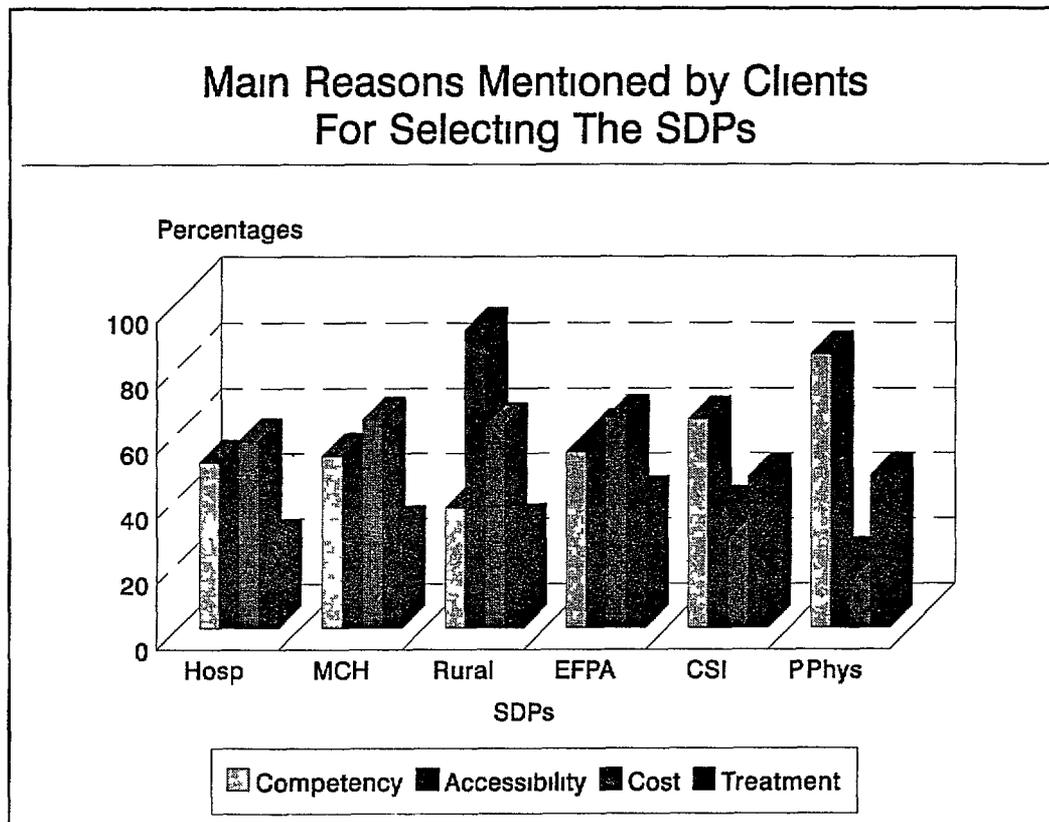
As shown in table 10, two other frequently mentioned reasons have to do with the site itself

- Easily accessible (49.2%)
- Well equipped and clean (12.9%)

More than nine out of ten rural centers/units' clients (91.2%) mention the accessibility of the site as a main reason for going there. A relatively high proportion of EFPA clients give the same reason (60%). As to the cleanliness of, and well-equipped facilities in the place, high proportion of CSI clients give that as one of the main reasons for choosing the place for service. A large proportion of hospital clients give that reason as well.

The appropriateness of the cost of the service is another reason that is frequently mentioned (43.0%). As may be expected, this reason is more frequently mentioned by EFPA, MCH, rural center/unit, and hospital clients. Figure 2 summarizes and illustrates the findings by presenting the four main reasons given by clients for selection of SDPs.

Figure 2 Main Reasons Mentioned by Clients For Selecting the SDP

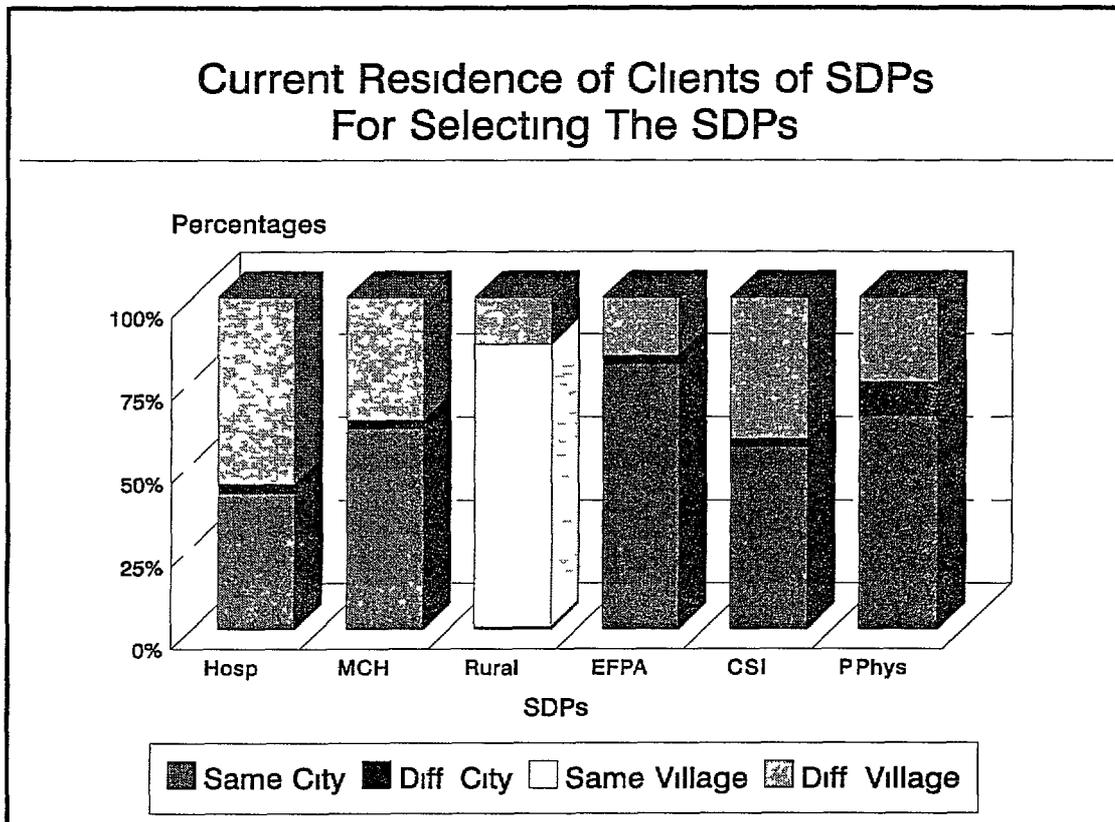


E COMPLEMENTARITY/COMPETITIVENESS OF SDPs

In order to investigate to what extent different SDPs serve different clients, i.e. complementarity of SDPs, a thorough review was carried out comparing a variety of socio-economic characteristics of clients of different SDPs

Though all sampled SDPs, with the exception of rural centers/units, are located in urban locations, they still provided services to clients from rural areas. Hospital clients had the highest proportion of village residents (56%), followed by CSI clients (44%). Of all SDPs, private physicians and EFPA clinics attract the fewest rural clients, but still around one fourth of their clients (25% and 22% respectively) reside in rural areas (see Tables 11 and 12). Available rural health services appear to be grossly inadequate in meeting rural women's reproductive health needs. Figure 3 illustrates the distribution of clients of the SDPs by place of residence.

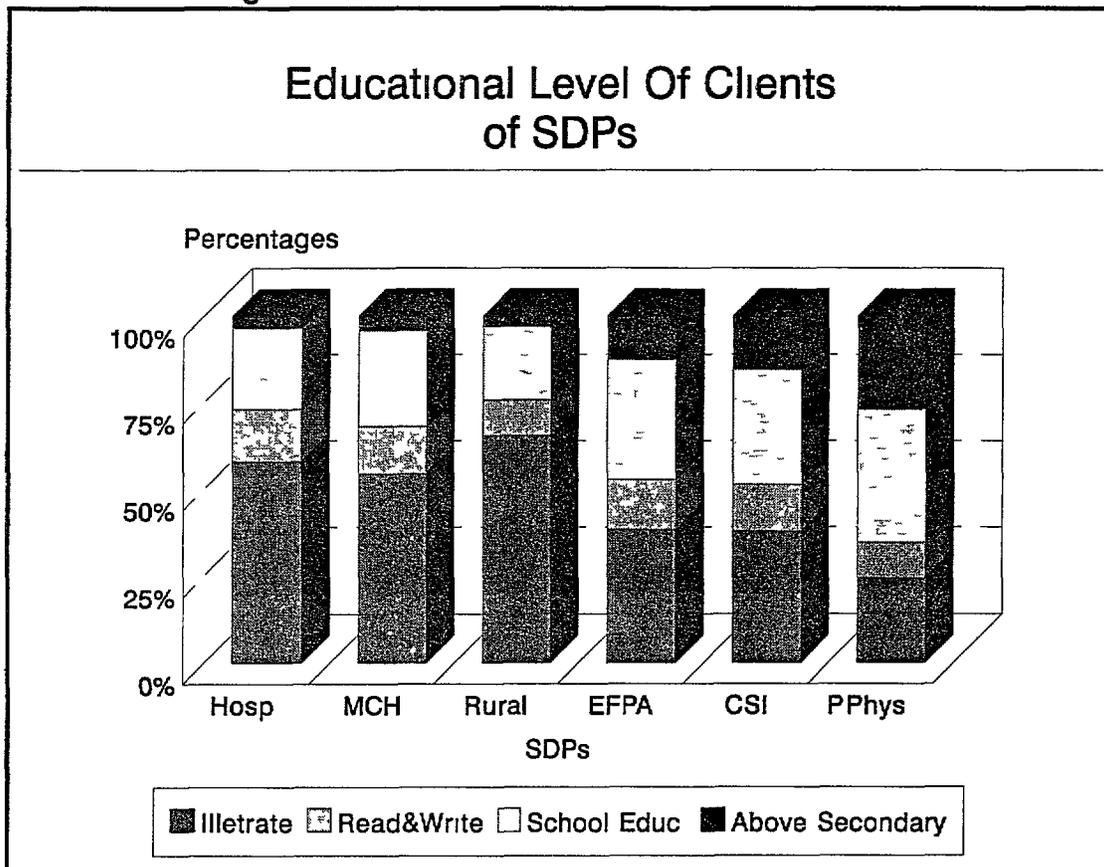
Figure 3 Current Residence of Clients of SDPs



There are no substantial differences in the age structure of clients of different SDPs all provide services to all age groups However, hospital and EFPA tend to serve higher proportions of clients 35 years and above (29% and 35% respectively), as compared to private physicians (22%) and MCH centers (21%), as is shown in Table 13

If age at first marriage could be used as a proxy for socio-economic levels and levels of modernity, as Table 13 demonstrates, it is evident that higher proportions of clients of rural centers/units, hospitals and MCH centers married at ages less than 16 years, the legal age of marriage (33%, 28%, and 26% respectively) In comparison, the proportion of clients of private physicians, EFPA or CSI clinics that married below the legal age are 11 percent, 16 percent, and 20 percent respectively The level of education of clients of the different SDPs also reflects the same pattern Higher proportions of rural centers/units, hospitals, and MCH centers' clients are illiterate, or can barely read and write (76%, 73%, and 68% respectively) as compared to clients of private physicians (34%), of CSI (51%) or EFPA clinics (53%), as shown in Table 14 This is illustrated in Figure 4 which shows the different educational levels of the SDPs' clients

Figure 4 Educational Level of Clients of SDPs



Clients of private physicians, CSI clinics, and EFPA clinics are more likely to have an occupation (30%, 30%, and 25% respectively) than clients of hospital clinics (18%) and MCH centers (17%) They are also more likely to be employed in professional or managerial occupations (37%, 24%, and 17% respectively) and less likely to have unskilled, farming, or casual labor occupations (see Table 15) The same pattern holds true for the husbands of the clients in terms of level of education and type of occupations, as shown in Tables 16 and 17

A number of variables related to housing characteristics and ownership of durable goods were also investigated to provide evidence of differences and/or similarities of clients of different SDPs, as shown in Tables 18, 19, and 20

Private physician clients stand out as being the clients with the highest proportions of all characteristics that indicate relatively higher socioeconomic levels they have the lowest per room density (1.19 persons per room), the highest proportion of homes connected to sewage systems (69%), and higher proportions own the durable goods investigated, with the exception of black-and-white TVs, bicycles, and sewing machines

EFPA and CSI clinics clients seem to reflect more the middle-class characteristics as they demonstrate lower socioeconomic levels than the private physician clients and higher socioeconomic levels than clients of hospitals, MCH centers, and rural centers/units Considering that CSI clinics draw more clients from rural areas than EFPA clinics, it seems that rural center/unit clients resorting to CSI clinics for service represent the relatively higher socioeconomic groups of rural societies

-
- *There are no substantial difference in the age structure of clients of different SDPs*
 - *About 75% of clients of rural centers, hospitals and MCH centers are illiterate*
 - *CSI, EFPA and private physicians likely to have an occupation*
-

The income and expenditure data, as presented in Tables 21 and 22,

demonstrate the same pattern The highest average monthly income and expenditures reported are those of private physician clients, followed by CSI clients, then EFPA clients Hospital and rural centers/units are similar, and on average slightly higher, than MCH center clients This indicates that hospitals tend to serve clients who have a combination of characteristics similar to urban MCH center and rural center/unit clients, i.e. the urban and rural low income clients

F. DIFFERENTIAL REPRODUCTIVE CHARACTERISTICS OF SDP CLIENTS

Reproductive characteristics are another dimension of the profile of clients of different SDPs. They include pregnancies, pregnancy losses, live births, child losses, surviving children, and patterns of contraceptive use.

1. Pregnancies, Live Births, and Surviving Children

Table 23 shows some selected reproductive indicators for the sampled clients. Fewer than one in ten clients have never been pregnant (9.1%), while 11.8 percent have never had a live birth, and one in every eight women does not have any surviving children (12.5%). The overall average number of pregnancies among the sampled clients is 3.8, resulting in an average 3.3 live births and netting an average 2.8 surviving children.

Each client has experienced an average loss of one child, either through pregnancy loss or death of a live child. It is worth noting that this is due to a relatively small proportion of the clients who have had comparatively high losses. One client out of every three has experienced a pregnancy loss, and among these, each lost an average 1.7 pregnancies. One in every four clients has lost a child, and these clients have lost 1.6 children on average.

Clients of the private physicians are distinguished as having the lowest average number of pregnancies, live births and surviving children. On the other hand, they are the clients who experienced the greatest pregnancy losses (35.8%). One possible explanation is that women experiencing problems in their pregnancies seek the help of private physicians. However, once the child was born, a much lower proportion (15.8%) lost a child through death.

This profile of private physician clients is consistent with other socioeconomic characteristics of these clients such as higher education, higher proportions in professional/managerial jobs, higher monthly incomes, and higher monthly expenditures. Private physician clients are also distinguished by the highest proportion who have never been pregnant (22%), have never had a live birth (30%), have no surviving children (31%), and who are currently pregnant (39%). This reflects the importance of obstetric and gynecological health services provided by the private physicians.

Clients of hospitals and rural health centers/units, as compared with clients of private physicians, are at the other end of the continuum. They have

Private physicians clients are of higher socio-economic standard while CSI and EFPA clients have a rather middle class profile

on average, two additional pregnancies (4.6 pregnancies each), twice as many live births (4.1 live births each) and surviving children (3.5 and 3.6 children respectively), and the highest proportions of those who have experienced child losses (32% and 34% respectively)

The profiles of clients of CSI, EFPA, and MCH clinics and centers fall in respectively descending order between clients of private physicians and of hospitals and rural centers/units in terms of average number of surviving children (2.9, 3.2, and 3.5 children respectively), and in proportions of clients who have experienced child losses (22%, 25%, and 28% respectively)

All respondents were asked if they desire to have more children, and according to the findings more than one in every four women (26.4%) express this desire, while a little over two out of every three (67.1%) say 'no'. The remaining clients (6.4%) are undecided. It is worth noting that a larger proportion of clients of private physicians (43.1%) are desirous to have additional children, possibly because of their low fertility and greater experience of pregnancy loss.

2 Contraceptive Use Patterns

Patterns of contraceptive use were investigated by determining contraceptive use status of clients and intentions to continue use. As shown in Table 23, more than four out of every five clients (78.6%) have used contraceptives, while the remaining 21.4 percent never used contraceptives. Among all clients, more than three out of five are current contraceptive users (60.6%). However clients of the different SDPs vary widely with respect to their current contraceptive use. The lowest proportion are clients of private physicians with less than one fourth (24.4%) current users. These are followed by hospital clients with more than two thirds (67.6%) current users. The highest proportion of current users are MCH clients with more than four out of every five (82.3%) being current users, followed in descending order by EFPA, rural centers/units, and CSI clinic clients (78.7%, 78.3%, and 71.4% respectively)

Never-users are found in large proportions among clients of private physicians (46.6%), the proportions range between 7 and 14 percent of the

clients of the other SDPs. This finding is consistent with the reproductive characteristics of the clients of the private physicians, among whom relatively large proportions have never had a live birth or been pregnant.

Among the current users, a large proportion (58 percent) are using the IUD while one in every three clients is using oral pills (33.1%). Injections are used by 5.8 percent, while other methods are less frequently used by the clients.

Over three quarters of the current users (76.5%) say they intend to continue use of the respective method. Fewer than one in every ten (9.2%) say they do not intend to continue use of the method. The main reason given for wanting to discontinue is that the method is causing them problems or side effects. However, most of these clients (91.3%) say they intend to use some other method.

It is worth noting that about two thirds of those wanting to discontinue were users of oral pills (65.8%) as compared to only 15.2 percent who were IUD users. Three out of four say they would use the IUD, while injections were the choice of 9.2 percent and 6.7 percent preferred oral pills. The main reason that was mentioned for the intention to continue use of the current method was that it was not causing any side effects.

The majority of those who were not currently practicing contraception (88.3%) say that they intended to use a method in the future, while the remainder (11.7%) said that they had no intention of using a method in the future. More than half of the latter group are clients of private physicians and the main reasons given was the desire to have children (41%), or the belief that they were unable to have more children (32%).

-
- *More than four out of every five clients have used contraceptives*
 - *Over three quarters of current users intend to continue using the respective method*
 - *Main reason for continuation was not experiencing any side effects*
-

3 Open Birth Interval

All clients that terminated at least one pregnancy were asked the history of their contraceptive use during the period since their last pregnancy till the time of the interview, i.e. during the open birth interval. They indicated the different methods used, including the current method and the duration of use of each method. Each time a client used a new method it is considered an

incident of use of that method. Thus, each use of one method for was a continuous period was counted as an incident of use.

Table 24 shows selected indicators of contraceptive use during the open birth interval. For all clients that terminated at least one pregnancy, the interval averages 34 months. This ranges from an average low of less than 30 months for clients of MCH centers to an average high of 40 months among clients of EFPA.

During this open birth interval, about one in every six clients did not use contraceptive methods (16.7%) while 46.7 percent have used only one method. Over one fourth of the clients used two methods during this interval, and more than one client in every ten (10.7%) used three or more methods. On average, each client used 1.6 contraceptive methods during this interval. More clients of private physicians did not use contraceptive methods at all, while those that used them made fewer changes.

Clients who used contraceptives during the interval used them for 29 months on average. This average period of use varies rather widely among clients of the different SDPs. Clients of the EFPA, who have a longer open birth interval, also used contraceptives for a longer average duration. Clients of private physicians used contraceptives for a relatively longer average duration (32.3 months), particularly in view of the average length of the period since the end of the last pregnancy (34.7 months).

Table 24 shows the incidence of use for some selected contraceptives during the

There are more incidents of IUD use than used oral pills

interval, together with the number of clients that used these methods and the ratio between the two. With the exception of the rural centers/units' clients, more clients used the IUD than used oral pills. The overall ratio of incidence of use to the number of clients is slightly lower, which may indicate staying longer with this method.

Clients use of some selected contraceptives (excluding the current method used) are presented in Table 25, together with the incidence of use and the average duration of use. The incidence of pill use slightly exceed the incidence of IUD use, although the average duration of use of IUDs is longer. With the exception of clients of rural centers/units and MCH centers, incidence of IUD use are greater than those of pill use among clients of all the SDPs. Injections are used by more clients of CSI.

G CLIENTS' VIEWS OF THE SERVICE

1 Cost of Service in Time and Money

Costs of services received by clients include the costs incurred in time and money for travel to and from the SDP and for the actual service received

Cost of Travel Time

In terms of travel time, as shown in Table 26, the majority of clients of rural centers/units (88.4%) and EFPA clients (66.6%) reach the SDPs on foot, indicating physical proximity and accessibility. MCH center clients are split, with slightly fewer than half (48%) reaching them on foot. In contrast, about two thirds or more of CSI (61.8%), private physician (66.3%), and hospital clients (82.8%) use some form of transportation other than walking to reach their respective SDPs.

The time spent by clients to reach their respective SDPs whether on foot or by another form of transportation, ranged from less than five minutes to more than an hour. The least average time spent on travel was for clients of rural centers/units (15.7 minutes), followed in ascending order, by MCH clients (20.2 minutes), EFPA clients (20.7 minutes), private physicians' clients (26.6 minutes), CSI clients (27.7 minutes), then hospital clients who spend on average about half an hour for travel (31.6 minutes). Regardless of the time spent to get to the SDP, the majority of the clients are of the opinion that the travel time was reasonable and not considered too long. In terms of time, travel was not considered too costly.

The cost of transportation to and from the respective SDP varies (from less than LE 0.50 to more than LE 3) depending on the type of transportation used and the distance travelled. The highest average cost (LE 1.50) was incurred by clients of private physicians as one in five used a private taxi (representing 81% of all those who used a private taxi) and one in seven used a private car (representing 85% of all those who used a private car). Significant proportions of private physicians' clients used a private or public bus (62%) and paid less than LE 0.50 (53%) for the two way trip.

Clients of CSI clinics have paid less (LE 0.90) than clients of private physicians, but still slightly more than clients of EFPA clinics (LE 0.70). Rural centers/units's clients paid the least average costs of transportation (LE 0.47). Regardless of cost incurred for transportation, the majority of all clients considered the costs suitable.

Waiting Time for Service

Though no money value could be estimated for the waiting time to obtain service, this time could be costly in terms of duration, uncomfortable waiting conditions, and psychological stress due to lack of priority order in selecting clients for service. As shown in Table 27, waiting time in general varied from immediate service to over an hour of waiting depending on the number of clients waiting to be served and/or the promptness of the SDP health providers.

Clients of rural centers/units and CSI clinics report the least average waiting time (15 and 19 minutes respectively), while hospital and private physician clients report the highest average waiting time (28 minutes).

Yet in terms of the reported comfort of the waiting conditions, CSI and private physician clinics are the best, as almost all clients are seated on a chair in a special waiting room or in a hall. Additionally, service was on a first come first served basis.

The worst waiting conditions were reported by clients of rural centers/units as only two in five (40%) waited in a waiting room or hall and only half reported sitting on a chair. The others either remained standing or sat on the floor in a courtyard or in corridors. Waiting conditions for clients of MCH centers and EFPA clinics are similar, but likely to be less comfortable than conditions at CSI and private physician clinics and more comfortable than waiting conditions of hospital clinics.

Cost of Service

All clients, first time or repeat visitors, whether receiving a family planning or a non-family planning service, were asked how much the service on that visit cost them. Tables 28 and 29 present the average costs for types of family planning and non-family planning services respectively, estimated only for clients who paid a fee for the visit.

Costs of family planning services vary by type of SDP. Private physicians charged the highest costs, an average of LE 12 for family planning services. The second highest cost for family planning services is charged by CSI clinics, an average of LE 8.3. The lowest average cost was charged by rural centers/units (LE 0.78). EFPA clinics, charged an average LE 2.8, hospital clinics LE 2.36, and MCH centers LE 1.68.

Willingness to Increase Cost of Service

With the exception of clients of rural centers/units, three out of four or more clients of all the other SDPs viewed the cost of the service as appropriate (see Table 30). A few clients (5.4%) thought the cost was too high; they were mostly clients of CSI and private physicians.

The proportion of clients willing to pay more for the service received were not high, ranging from 16 percent of clients of rural centers/units to ten and nine percent of private physician and hospital clients respectively. Even with other

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- *Average time spent to reach an SDP is about 23 minutes*
 - *Average waiting time is about 20 minutes*
 - *Highest charged cost of service was LE 12 for private physicians, and LE 78 for rural centers*
-

obstetric and gynecological services, the majority of clients were of the opinion that the money they paid for the service they received was appropriate, though 10% see it as expensive, mainly among hospital and MCH clients (12% and 18% respectively).

2 QUALITY OF THE SERVICE

A number of indicators demonstrate the quality of the service received by the clients. These include the reception, information given to the client on range of services available at the SDP, physical examination before contraceptive method selection, counselling in selection of method, and scheduling the time of next visit.

Reception and Information at the SDP

As shown in Table 31, 87 percent of clients stated that on arrival at the SDP, they were met by someone who asked what service they required, while 13 percent state that nobody did so. 57% of respondents said that the person who met them recorded their data on a card. However, there are pronounced variations among the SDPs, with 92 percent of CSI clients stating this and only 45 percent of private physician clients. In between, were MCH center, EFPA hospital, and rural centers/units' clients (72.2%, 60.9%, 53.3%, and 53% respectively).

Only 30 percent of respondents stated that someone explained to them the services available at the SDP. The highest proportion of these clients were again CSI clients (49.5%), closely followed by the other SDPs, with the exception of hospital clients of whom only 12.6 percent stated so.

In spite of the relatively high score of the CSI clinics in terms of reception of clients, recording information and briefing clients, the highest proportion of clients who state that they had a chance to ask questions are those of private physicians (82.7%), followed by CSI clients (67.4%). The majority of clients who asked questions in all SDPs however (98.2%), said that they received clear answers.

More than two out of five of all clients requiring family planning services said that they were briefed about the available contraceptives, CSI had the highest proportion that were given information (78.6%). The majority (88.9%) of clients who were briefed about contraceptives available, stated that they got clear information.

Selection and Information on Method

Almost three quarters (73%) of clients were physically examined before they made a choice of contraceptives (see Table 32). However while the majority of private physician and CSI clients (96.9% and 95.4% respectively) had an examination only 55 percent of rural clients were examined so. There is a very large difference between the number of CSI and private physician clients who had a laboratory investigation (73.7% and 14% respectively).

Clients were asked who selected the contraceptive method they were using. While about three out of five of clients from hospitals, MCH centers, and rural centers/units stated that they made the choice themselves, only about two out of five of EFPA, CSI, and private physician clients made the choice. Looking at the proportions of clients who stated that the choice was made by the physician or the client and physician together, it appears that while the physicians have a larger role in EFPA, CSI, and private physician clinics, there also appears to be more physician/client interaction in these SDPs, particularly in the latter two types.

With the exception of rural centers/units, the IUD is the contraceptive method selected for the majority of clients of all the SDPs, with most of these clients (88.4%) stating that they were briefed on how to check that the IUD was in place. For other contraceptives selected, three quarters of the clients stated that they had been briefed on the correct method of use.

Information regarding possible side effects and/or complications of the method used was given to 70 percent of clients (87% of private physician, 76% of CSI, 75% of EFPA, 71% of MCH, 65% of rural center/unit and 58.5% of hospital clients). Of those to whom such information has been given, the

majority (91.9%) were told what to do in case of occurrence of a complication or problem

Only 52 percent of clients who were currently using a contraceptive were informed that they could switch to another method if there were problems (over 60% of private physician and CSI clients, but less than half of MCH and hospital clients)

Service Time, Scheduling of Next Visit and Follow-Up

With the exception of rural center/unit clients, more than four out of five of the clients of all the SDPs stated that the time spent with the physician was adequate. In terms of total time spent at the SDP, the majority (88%) of clients in all the SDPs said that it was reasonable and also that working hours and days were considered suitable.

A follow up visit was scheduled for 70.5 percent of clients of CSI clinics and for more than half the clients of hospitals and private physicians. A return visit only was scheduled for one

A follow up schedule was provided to 70% of CSI clients and more than half of hospital clients, while only 26% of rural centers clients were given this schedule

quarter of clients of rural centers/units, more than one third of MCH center clients and more than two out of five of EFPA clients. It is interesting to note that the highest proportion of clients who state that they believe the SDP will contact them if they miss a follow-up visit are the clients of the rural centers/units (29%), followed by EFPA (16.9%) and CSI (15.2%).

3 INTENTION TO CONTINUE USING THE SERVICE OF THE SDP

Regarding the intention to continue use of the SDP, 98.3 percent of family planning clients expressed their intention to continue using the services of the SDP. There were no significant differences by type of SDP as can be seen from Table 3.3. It should be noted that the reliability of the professed intentions may be questionable as exit interviews carried out at the premises of the SDP may force such an answer.

H CLIENTS' KNOWLEDGE AND USE OF OTHER SDPS

Clients were asked to mention any other SDP they knew of that offer family planning services. Whenever an SDP was mentioned they were asked if they had been there for family planning services. Although the interview

schedule included different categories of SDPs, these were not shown to the respondents, but rather were marked if mentioned, i.e. based on unprompted recall. This explains, at least partly, the high percentage of clients specified as not mentioning the various service points (see Table 34)

In terms of mentioning a site as offering family planning services, despite not getting any service there themselves, the highest proportion of clients cited general hospitals (37%). This was followed by CSI clinics which were mentioned by about one third of the clients, a significant finding in view of the fact that CSI clinics are relatively new as outlets for family planning services. One out of every four clients has mentioned names of specific private physicians that she knew of, although she had not obtained service there, while one in five mentioned the MCH.

With respect to use of the SDPs which were mentioned as offering family planning services, the highest proportion of clients went to private physicians and pharmacies with one in five clients in each category respectively citing use of these two SDPs.

Clients were further asked of their intention to continue getting service at the respective SDP, and the great majority stated they would (97%). This was the case for clients of the different SDPs (see Table 35). The main reason given by those who intended not to continue to get service at the respective SDP was dissatisfaction with the service. Another frequently mentioned reason was that the client did not need the service any longer. A relatively large proportion of the clients of rural health centers/units who intended to discontinue service there stated their reason as the unavailability of the required service.

I. REASONS FOR SHIFTING FROM SDPS

Clients who shifted from one SDP to another were asked to specify the reasons for quitting the respective SDP. Clients were probed to specify up to four reasons. A total of 34 different reasons were mentioned, and all given reasons were cumulated and examined in relation to the category of the SDP that was left.

Table 36 presents the most frequently mentioned reasons for leaving the different SDPs, along with the percentage of times such a reason was mentioned in relation to a shift among the categories of SDPs.

The reasons can be grouped into four categories

- 1 Site related 'inaccessibility of the site' This reason was given in two out of every five shifts from a CSI clinic, 35 percent of shifts from hospitals, and one third of those from EFPA
- 2 Contraceptive method 'side-effects and complications' experienced by using a certain method which was given most frequently by clients for shifts from pharmacies (41.6%) It was also given for one third of shifts from a MCH center About one out of every four shifts from a private physician or a CSI clinic is due to the same reason 'Dissatisfaction with the method' is another method-related reason mentioned more frequently for shifting from a pharmacy (16.4%)
- 3 Provider related 'incompetence of the service providers' mentioned more frequently for quitting service at a hospital or a rural center/unit (11.8% and 10.1% respectively), while 'negligence, disrespect, and ill-treatment' is an additional frequently mentioned reason for shifting from a hospital (11.8%)
- 4 Service related 'high cost of the service' is the reason given more frequently for shifting from a private physician (38.9%) and also for shifting from a CSI clinic (26.9%) The 'irregular availability of the method' in the respective site is mentioned more frequently for shifting from a rural site The 'absence of examination' was mainly given for the shifting from pharmacies (47.3%)

Most frequently mentioned reasons for shifting from SDP were side effects, dissatisfaction with the method and inaccessibility of sites

J. CLIENTS' INTERSHIFTING STREAM BETWEEN SDPS

As mentioned earlier, clients were asked to mention any other SDPs they had been to for family planning services Those clients who had obtained such services in one or more delivery points, were further asked to rank order these places chronologically

The focus of analysis in this section is on the last four delivery points (including the current SDP) from which clients obtained family planning services. Almost half of the clients shifted to the current SDP (49.1%) from another service location, whereas the rest of the clients (50.9%) had not obtained family planning services elsewhere (see Table 37). Shifters are found in larger proportions among CSI and hospital clients (64.8% and 63.7% respectively). In contrast, slightly more than two out of five clients of private physicians and rural health centers/units shifted providers (41.6% and 44.1% respectively).

Among those who shifted to the current SDP, 62.1 percent have shifted once, (26.5%) shifted twice. Only 11.4 percent made three or more shifts coming to the current SDP. Among shifters, each client shifted 1.5 times on average, with little variation among the clients of the different SDPs.

In order to examine the shifting streams among the various delivery points, each shift was treated as a separate unit of observation, consequently all shifts are aggregated together. It is possible to identify the point of departure and the point of destination for each shift. For analytical purposes all mentioned SDPs were categorized into seven groups:

- 1 Hospitals
- 2 MCH centers
- 3 Rural health centers/units
- 4 EFPA clinics
- 5 CSI
- 6 Private physicians
- 7 Pharmacies²

According to the data there has been a total of 3,527 shifts by 2,311 clients. In examining the shifts to and from the various SDPs, it became clear that certain SDPs have had a net gain of clients, and other SDPs experienced net loss. The net gain was highest among the rural health centers/units. The CSI and EFPA's clinics also experienced considerable net gain, while the MCH's had a much lower net gain. Pharmacies experienced high net losses of clients. Much lower losses were experienced by private physicians and hospitals.

² Pharmacies were mentioned as places where clients went to for family planning services.

Another way of looking at these movements is from the perspective of different SDPs. Here each move whether to or from is counted as a move. According to this perspective, private physicians had the largest share of these movements (28.3%). Pharmacies and hospitals also experienced large proportions of these movements (17.3% and 14.6% respectively). The EFPA, CSI and MCH have a much lower share of these movements (7.4%, 8.8%, and 9.5% respectively -- see Tables 38 and 39).

The data also showed the largest proportion of shifts were from private physicians (28.8%). Over 27 percent of these shifts were to other private physicians, while about one out of every five clients shifted to a rural outlet (19.3%). It is quite plausible that these shifts were from clients who were originally rural dwellers and sought the service of a private physician to deal with a particular problem, but then went back to rural health centers/units for regular service.

A relatively large proportion of shifts were from pharmacies (26.9%), of which more than one fourth were to private physicians (26.1%) and a relatively lower proportion (23.4%) shifted to rural health centers/units. About 15 percent of the shifts were from hospitals, of which three out of every ten were to private physicians (29.7%), while 17.9 percent were to rural health centers/units.

All types of SDPs win and lose clients from each other. However, pharmacies followed by private physicians are the greatest losers.

The data also showed many fewer shifts from the EFPA clinics. Five out of every 100 shifts were from these SDPs, of which three out of every ten were to private physicians.

Although private physicians experienced net loss on the whole, 27.9 percent of all shifts were to private physicians. The large proportion of these shifts were from other private physicians. One in every four of these shifts was from pharmacies (25.3%) and about 16 percent were from hospitals.

Fewer than one fifth of all shifts were to obtain service from rural health centers/units (19.1%). Of these, almost one third were from pharmacies while 29 percent were from private physicians.

Although net losers, hospitals received over 14 percent of the shifts. The largest portions of these shifts were from private physicians and pharmacies (27.8% and 25.6% respectively).

Figures 5 and 6 illustrate the shifts from and to the various SDPs. Figure 5 presents the shifts from the MOH facilities, namely the hospitals, rural centers/units and MCH centers, to the various SDPs, while Figure 6 presents the shifts from the private/public facilities, namely private physicians, CSI and EFPA clinics, to the various SDPs.

Figure 5 SHIFTS FROM MOH FACILITIES TO VARIOUS SDPs

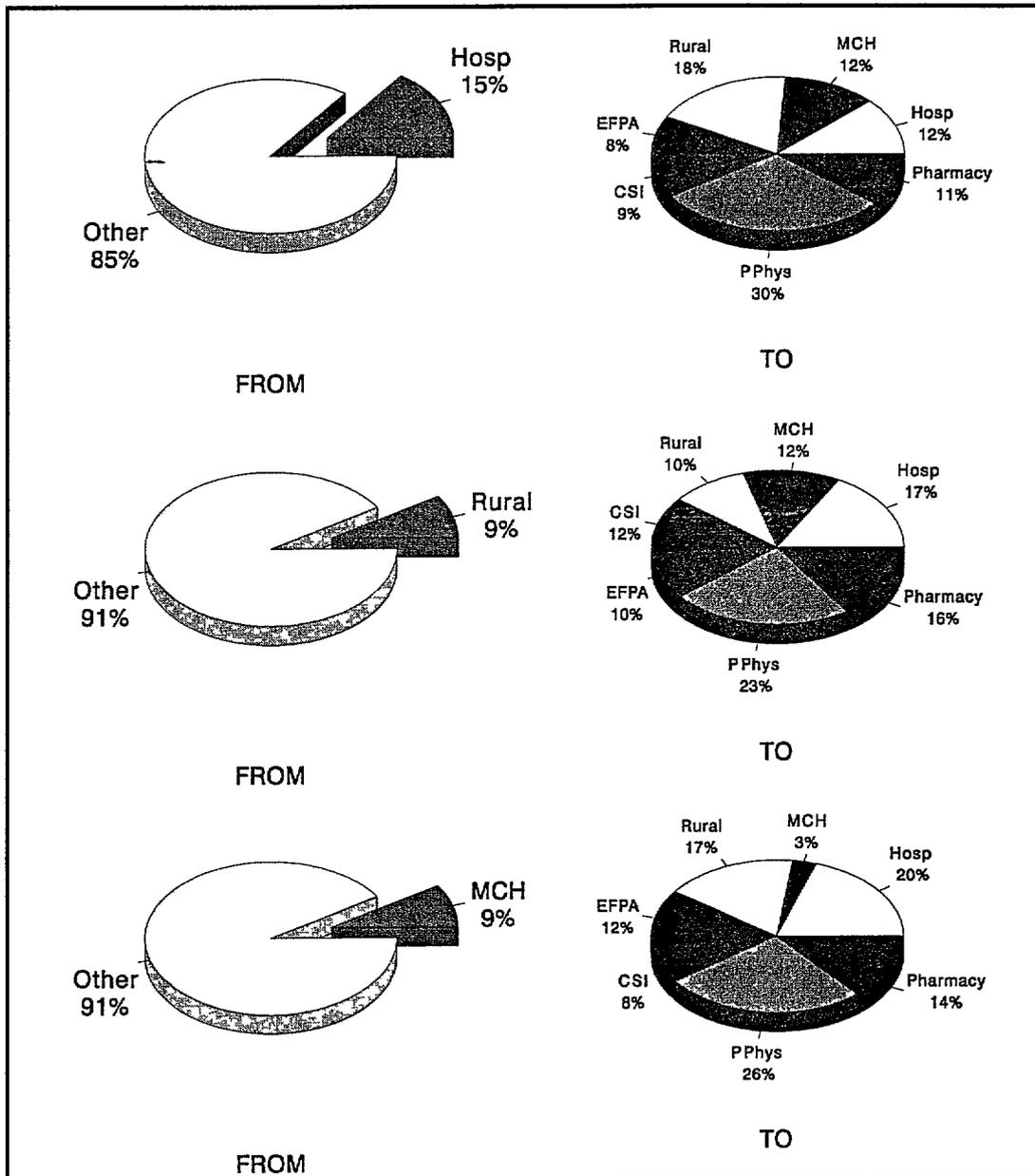
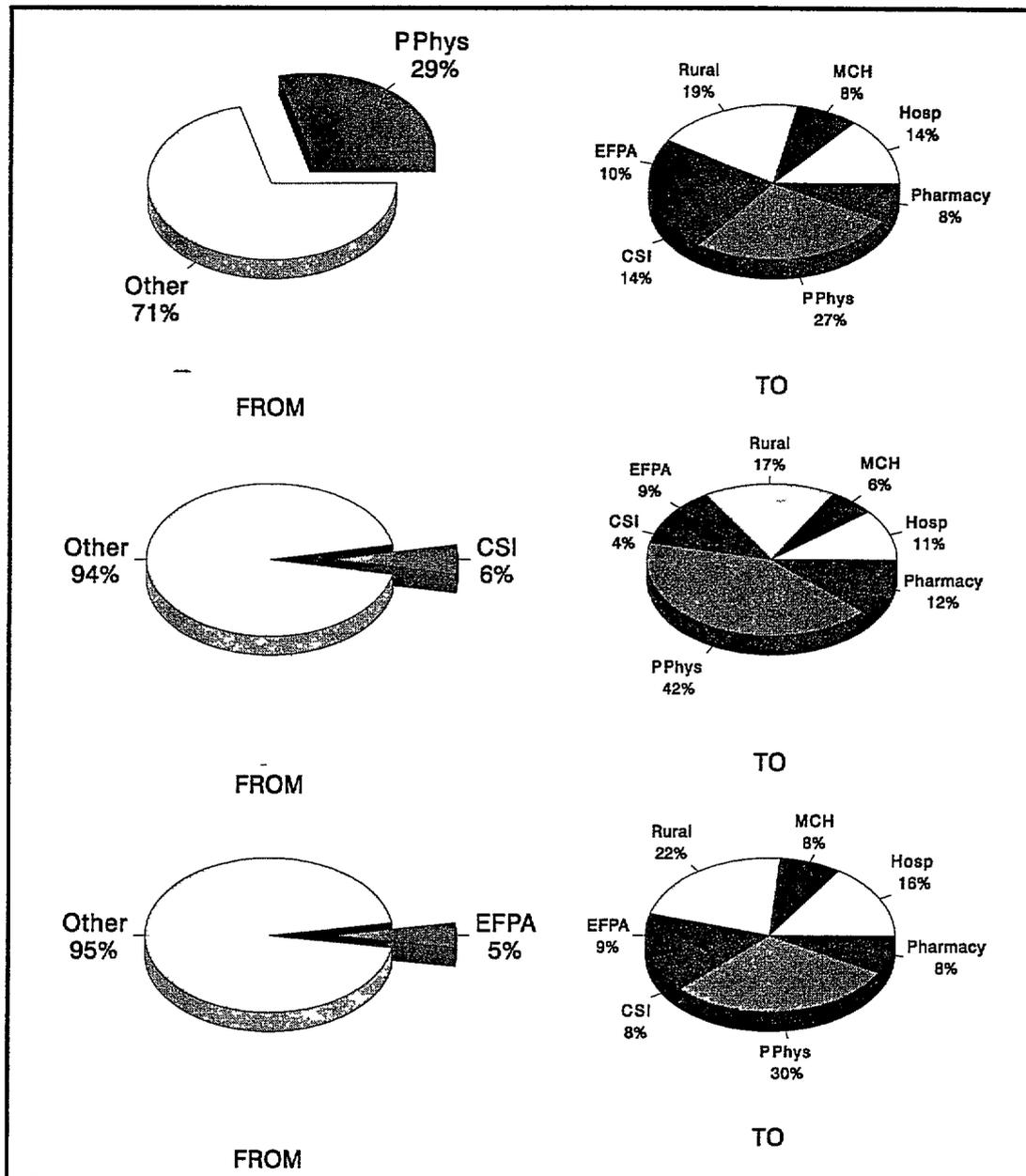


Figure 6 SHIFTS FROM PRIVATE/PUBLIC FACILITIES TO VARIOUS SDPs



respect is also more frequently reported as a reason for going to CSI clinics and private physicians. Additionally, CSI clinics have clean, well-equipped premises, and private physicians provide good quality service in terms of competence and trustworthiness.

3. Client satisfaction with the service received is the best promoter for the SDP through word of mouth. Yet CSI has successfully used mass communication channels for promoting their services and has attracted clients. Other clinics could do the same. Clients' awareness of the various options they have in selecting family planning service delivery points is inadequate. More is needed from these centers/clinics to promote their services to their target clients.
4. Regardless of the variations in time and money clients invested for reaching the SDP and for receiving the services, the majority were of the opinion that the cost in time and money was reasonable. Also, regardless of the uncomfortable conditions that some clients were exposed to in waiting for the service, such as not having a chair to sit on, waiting in corridors or court-yards, etc., still the majority declared at the exit interview that they would continue to use the services of the same SDP.
5. Some clients do continue to use the services of one SDP and some clients shift to services of other SDPs. General dissatisfaction, experienced side effects and complications of the contraceptive method used are the major reasons stated for shifting from one SDP to another. Dissatisfaction with service providers in terms of incompetence, negligence, disrespect for clients, and ill-treatment are reasons for shifts especially related to shifts from rural centers/units, hospitals, and MCH centers. Irregular availability of methods and absence of physical examination by physicians are also reasons for shifting from rural centers/units. Inaccessibility of place of service is another reason why clients shift from hospital and EFPA clinics. High cost of service as a reason for shifting is associated more with shifts from private physician and CSI clinics. All these reasons provide major guidelines to what women need and look for in their search for the place to go to for family planning and related services.

- 6 There are no clear patterns of shifting FP services between different SDPs. All types of SDPs win and lose clients from each other. However, private physicians tend to lose clients mostly to other private physicians followed by losses to CSI clinics, then to hospital clinics. The greatest proportion of shifts to CSI clinics come from private physicians, shifts from CSI clinics go mostly to private physicians followed by rural center/units then to hospital clinics.
- 7 Increasing costs of family planning services is not welcomed by the majority of clients. Yet slight increases in cost of services of rural centers/units and MCH centers, if accompanied by significant improvements in the service provided, may be easily accepted by clients as relatively higher proportions of these clients view the cost of service received as cheap. The service improvements should include improvements in obstetric and gynecological services offered to low income women, especially rural women who have to travel to urban clinics to receive these services. Further analysis of the data may provide greater evidence about which service at which type of SDP could have the cost increased in the views of clients.
- 8 Cost recovery goals are more likely to be successful if they are achieved through improvements in the quality of health providers and services offered, which in turn will lead to increased utilization of facilities, and increased efficiency of contraceptive use.

APPENDIX

TABLE 1
CLIENTS BY GOVERNORATE AND TYPE OF INTERVIEW

TYPE OF INTERVIEW	CAIRO	ALEX	GHARBIA	SHARQIA	GIZA	MINIA	TOTAL
N	456	420	952	955	952	975	4710
% from Total	9.7	8.9	20.2	20.3	20.2	20.7	100.0
<i>Percentage</i>							
Client in Site	96.5	97.4	79.8	77.5	85.3	75.4	82.7
Client at Home	0.4	---	14.0	15.5	8.3	15.0	10.8
Drop-out	3.1	2.6	6.2	7.0	6.4	9.6	6.5

TABLE 2
CLIENTS BY GOVERNORATE AND TYPE OF SDP

TYPE OF SDP	CAIRO	ALEX	GHARBIA	SHARQIA	GIZA	MINIA	TOTAL
N	456	420	952	955	952	975	4710
% from Total	9.7	8.9	20.2	20.3	20.2	20.7	100.0
<i>Percentage</i>							
HOSPITAL							
General	4.4	5.0	9.0	8.9	8.7	10.1	8.3
Teaching	5.0	---	---	---	---	---	0.5
University	---	5.2	---	---	---	---	0.5
MCH	9.2	11.0	8.8	9.4	9.0	9.4	9.3
EFPA	18.4	10.2	9.3	9.1	9.5	8.8	10.2
CSI	10.1	10.7	9.5	9.1	9.6	9.7	9.6
RURAL							
Health Unit	---	---	19.4	19.3	23.5	19.1	16.5
Health Center	---	---	18.7	19.0	14.2	18.9	14.4
PRIVATE PHYSICIAN	53.0	57.9	25.3	25.2	25.5	24.0	30.4

TABLE 3
CLIENTS BY TYPE AND REASON OF VISIT TO SDP

TYPE & REASON OF VISIT	HOSP	MCH	RURAL	EFPA	CSI	P PHYS	TOTAL
N	413	413	1289	440	408	1441	4404
% from Total	9.4	9.4	29.3	10.0	9.3	32.7	100.0
<i>Percentage</i>							
FIRST TIME VISIT,							
Family Planning Services	21.8	24.0	9.5	13.6	19.4	3.1	11.2
Other Services	11.1	4.1	4.6	5.9	9.1	20.2	10.8
REPEAT VISIT,							
Family Planning Services	46.2	62.0	72.9	64.5	54.6	14.8	47.8
Other Services	20.8	9.9	13.0	15.9	16.9	61.9	30.1
TOTAL FP SERVICES	68.0	86.0	82.4	78.1	74.0	17.9	59.0
TOTAL NON-FP SERVICES	31.9	14.0	17.6	21.8	26.0	82.1	40.9

TABLE 4
FIRST TIME VISIT FAMILY PLANNING CLIENTS BY TYPE OF SERVICE OBTAINED

TYPE OF SERVICE	HOSP	MCH	RURAL	EFPA	CSI	P PHYS	TOTAL
N	90	99	122	60	79	45	495
<i>Percentage</i>							
Pills	3.3	6.1	33.6	11.7	8.9	6.7	13.5
IUD	58.9	82.8	40.2	55.0	49.4	26.7	54.1
Foam Tablets	1.1	1.0	0.8	---	2.5	2.2	1.2
Condoms	1.1	1.0	---	---	3.8	---	1.0
Injections	15.6	3.0	---	6.7	21.5	---	7.7
Didn't get FP method	20.0	6.1	25.4	26.6	13.9	64.4	22.5

TABLE 5
FIRST TIME VISIT (NON FAMILY PLANNING CLIENTS) BY TYPE OF SERVICE OBTAINED

TYPE OF SERVICE	HOSP	MCH	RURAL	EFPA	CSI	P PHYS	TOTAL
N	46	17	59	26	37	291	476
<i>Percentage</i>							
Sterility Treatment	13.0	5.9	---	7.7	10.8	16.5	12.8
Pregnancy Monitoring	13.0	58.8	59.3	7.7	35.1	32.7	33.9
Gynecologic Exam	39.2	23.5	17.0	50.0	18.9	32.7	30.9
Lab Investigation	6.5	11.8	1.7	7.7	29.7	1.4	4.8
Other Treatment	28.3	---	22.0	26.9	5.5	16.7	17.6

TABLE 6
REPEAT VISIT (FAMILY PLANNING CLIENTS) BY TYPE OF SERVICE OBTAINED

TYPE OF SERVICE	HOSP	MCH	RURAL	EFPA	CSI	P PHYS	TOTAL
N	191	256	940	284	223	213	2107
<i>Percentage</i>							
IUD Follow-Up	40.3	42.6	21.1	43.3	52.0	53.1	34.9
IUD Insertion	24.6	30.1	9.4	14.4	13.0	19.2	15.3
Pill Supply	5.2	12.5	62.2	23.2	4.0	6.6	34.0
Periodical Injection	15.7	1.2	0.2	6.7	19.7	3.3	5.0
Resupply of Other Contra	1.0	2.0	2.2	2.5	2.2	---	1.8
Other Related Services	13.2	11.6	4.9	9.9	9.1	17.8	9.0
Average Months Since 1st Visit	35.3	43.0	53.7	48.2	16.3	40.1	44.6

TABLE 7
REPEAT VISIT (NON-FAMILY PLANNING CLIENTS) BY TYPE OF SERVICE OBTAINED

TYPE OF SERVICE	HOSP	MCH	RURAL	EFPA	CSI	P PHYS	TOTAL
N	86	41	168	70	69	892	1326
<i>Percentage</i>							
Sterility Treatment	3.5	---	1.8	1.4	8.7	9.5	7.4
Pregnancy Monitoring	14.0	58.5	60.7	28.5	37.6	51.6	48.7
Gynecologic Exam	46.6	17.1	18.5	31.4	24.6	22.6	24.1
Lab Investigation	4.7	2.4	4.2	4.3	11.6	2.0	3.1
Other Treatment	31.2	22.0	14.8	34.4	17.5	14.3	16.7
Average Months Since 1st Visit	48.6	23.6	39.5	39.2	12.8	23.0	27.1

TABLE 8
CLIENTS ACCORDING TO SOURCE OF INFORMATION ABOUT SDP

SOURCE OF INFORMATION	HOSP	MCH	RURAL	EFPA	CSI	P PHYS	TOTAL
N	413	413	1289	440	408	1441	4404
<i>Percentage</i>							
TV	1.9	1.0	0.4	0.9	5.1	0.1	1.0
Nurse/Midwife/Soc Worker	6.0	5.6	17.5	8.8	12.7	3.2	9.4
Neighbor/Friend/Relative	69.0	75.5	49.7	68.4	47.8	76.8	64.5
Husband	4.1	2.4	4.4	2.5	1.7	6.6	4.5
Raida/Health Visitor	0.2	1.7	4.7	5.2	11.0	0.4	3.2
Billboards/Ads/Leaflets	12.1	5.6	7.3	10.0	20.6	6.0	8.7
Close by	4.1	6.8	14.0	3.0	0.5	2.0	6.1
Other	2.6	1.4	2.0	1.2	0.6	4.9	2.6

TABLE 9
CLIENTS ACCORDING TO SOURCE OF MOTIVATION TO GO TO SDP

SOURCE OF MOTIVATION	HOSP	MCH	RURAL	EFPA	CSI	P PHYS	TOTAL
N	205	244	649	256	251	935	2540
<i>Percentage</i>							
TV/Radio/Newspaper	---	0 8	1 3	0 8	0 8	1 0	1 0
Nurse/Midwife/Soc Worker	10 7	7 0	30 0	9 7	19 1	3 3	13 3
Neighbor/Friend/Relative	75 1	84 8	51 0	74 2	59 0	77 4	69 1
Husband	12 2	6 6	11 9	6 3	6 0	14 8	11 3
Raida/Health Visitor	0 5	0 8	5 1	8 6	15 1	0 9	4 1
Other	1 5	---	0 7	0 4	---	2 6	1 2

TABLE 10
MAIN REASONS MENTIONED BY CLIENTS FOR SELECTING THE SDP

REASONS*	HOSP	MCH	RURAL	EFPA	CSI	P PHYS	TOTAL
N	413	413	1289	440	408	1441	4404
<i>Percentage</i>							
Competency of Serv Prov	50 8	52 8	36 8	53 9	64 0	84 0	59 3
Easily Accessible	25 7	41 9	91 2	60 0	36 5	20 7	49 2
Appropriateness of Cost	57 4	63 9	62 0	64 5	27 0	14 0	43 0
Care/Respect/Good Treat	26 4	30 5	31 1	39 5	46 3	46 7	38 0
Trust Providers	19 8	29 0	20 7	30 0	29 6	56 1	34 7
Presence of Female Doctors	17 7	37 8	19 9	25 2	37 7	19 1	23 3
Well-Equipped & Clean	17 9	13 8	4 2	11 4	37 5	12 6	12 9
Good Follow-Up System	10 9	10 2	5 3	5 2	12 7	14 8	10 0

* More than one answer, so percentages do not add up to 100%

TABLE 11
CLIENTS ACCORDING TO RESIDENCE LOCATION

	HOSP	MCH	RURAL	EFPA	CSI	P PHYS	TOTAL
N	438	440	1457	479	454	1442	4710
TYPE OF RESIDENCE (% in)							
Metropolitan	16.7	20.2	0.1	25.1	10.8	32.7	17.1
City Lower Egypt	11.9	13.9	0.3	27.8	16.3	18.0	12.4
City Upper Egypt	15.1	28.9	0.6	25.1	28.6	23.7	16.9
Village Lower Egypt	29.0	25.5	49.5	9.6	22.7	15.5	28.3
Village Upper Egypt	27.4	11.6	49.4	12.5	21.6	10.0	25.3
PRESENT RESIDENCE (% in)							
Same city as SDP	41.1	60.5	---	80.0	55.0	64.3	42.6
Different city	2.7	2.5	0.7	2.5	2.4	10.2	4.3
Same village as SDP	---	---	85.1	---	---	---	26.3
Different village	56.2	37.0	14.1	17.5	42.6	25.5	26.8
LENGTH OF RESIDENCE IN PRESENT LOCATION (% in)							
0 - 10 years	16.4	15.9	13.0	15.4	20.9	18.6	16.3
11 years+	11.4	7.3	8.2	9.2	11.7	6.7	8.4
All her life	72.1	76.8	78.7	75.4	67.4	74.8	75.3

TABLE 12
CLIENTS ACCORDING TO CLIENT'S CHILDHOOD* RESIDENCE AND HUSBAND'S CHILDHOOD RESIDENCE

	HOSP	MCH	RURAL	EFPA	CSI	P PHYS	TOTAL
N	438	440	1457	479	454	1442	4710
Percentage							
CLIENT'S CHILDHOOD RESIDENCE							
Metropolitan	14.4	18.4	2.2	25.1	16.1	34.3	18.3
City Lower Egypt	11.9	13.9	4.5	25.1	20.3	17.3	13.6
City Upper Egypt	12.3	24.1	2.3	21.3	20.0	19.0	14.0
Village Lower Egypt	32.4	27.7	45.9	13.4	22.7	17.1	28.6
Village Upper Egypt	29.0	15.7	45.0	15.2	20.5	11.6	25.1
Other (abroad)	---	0.2	0.1	---	0.4	0.7	0.3
HUSBAND'S CHILDHOOD RESIDENCE							
Metropolitan	13.9	18.9	0.8	24.0	15.9	32.0	17.0
City Lower Egypt	13.2	13.0	1.6	26.1	18.1	18.7	13.1
City Upper Egypt	13.7	26.6	1.2	21.9	20.0	19.3	14.2
Village Lower Egypt	30.4	26.4	48.2	11.5	23.3	16.4	28.6
Village Upper Egypt	28.5	15.0	48.1	15.4	21.8	12.1	26.3
Other	---	0.2	0.1	0.2	0.4	0.6	0.3
Other	0.2	---	---	0.8	0.4	0.9	0.4
No Answer/Single/Divorced							

* Note Childhood refers to up to 12 years of age

TABLE 13
CLIENTS ACCORDING TO AGE AND CHARACTERISTICS OF CLIENT & HUSBAND

	HOSP	MCH	RURAL	EFPA	CSI	P PHYS	TOTAL
N	438	440	1457	479	454	1442	4710
CLIENT'S AGE (% who are)							
< 20 years	3 0	3 9	5 4	2 1	5 7	3 7	4 2
20 - 24 years	20 1	28 0	20 2	14 6	19 2	22 1	20 8
25 - 29 years	25 6	29 3	26 3	21 5	26 9	28 1	26 7
30 - 34 years	22 1	17 5	23 8	26 3	21 6	24 1	23 2
35 - 39 years	17 1	14 1	15 0	20 5	14 8	13 9	15 3
40 - 44 years	8 7	5 5	7 1	12 1	8 4	5 6	7 3
45 years +	3 4	1 8	2 2	2 9	3 5	2 4	2 5
Avg (years)	30 2	28 5	29 4	31 6	29 8	29 3	29 6
S D (years)	7 0	6 6	6 7	6 6	7 2	6 5	6 7
CLIENT'S AGE AT FIRST MARRIAGE (% who were)							
< 16 years	28 3	26 4	32 9	16 1	19 6	11 2	22 3
16 - 19 years	46 8	42 5	46 1	42 4	36 3	28 6	39 1
20 - 24 years	19 2	25 2	18 7	30 9	31 7	40 2	28 4
25 years +	5 7	5 9	2 3	10 4	12 1	19 6	10 0
N A (Single)	---	---	---	0 2	0 2	0 4	0 2
Avg (years)	17 7	18 0	17 0	19 1	19 2	20 8	18 7
S D (years)	3 6	3 7	3 0	3 8	4 3	4 5	4 1
DIFF IN AGE BETWEEN CLIENT AND HUSBAND (% with)							
- ve (Husband younger)	4 3	2 5	2 8	2 3	3 1	2 0	2 6
0 (Equal age)	4 6	5 2	4 3	4 6	4 6	5 0	4 7
1 - 4 years difference	30 9	32 5	30 7	30 3	31 4	31 8	31 2
5 - 9 years difference	36 8	36 1	37 5	38 1	37 2	39 5	37 9
10 - 14 years difference	16 5	16 8	17 5	19 8	20 6	17 1	17 8
15 years difference +	6 9	6 8	7 2	4 8	3 1	4 6	5 7
Avg (years)	6 3	6 4	6 6	6 5	6 2	6 2	6 4
S D (years)	5 7	5 5	5 3	5 1	4 7	4 8	5 1

TABLE 14
CLIENTS ACCORDING TO LEVEL OF EDUCATION

LEVEL OF EDUCATION	HOSP	MCH	RURAL	EFPA	CSI	P PHYS	TOTAL
N	438	440	1457	479	454	1442	4710
<i>Percentage</i>							
Illiterate	58.0	54.5	65.5	38.2	37.7	24.3	45.7
Read & Write	15.1	13.6	10.4	14.6	13.7	10.3	11.8
Primary	4.6	7.3	3.9	6.7	3.3	4.8	4.8
Preparatory	5.0	3.4	3.1	5.2	5.9	5.9	4.6
Secondary	13.9	17.0	14.2	22.8	24.0	27.8	20.4
Above Secondary Education	3.4	4.1	3.0	12.5	15.4	26.9	12.7

TABLE 15
CLIENTS ACCORDING TO OCCUPATION

	HOSP	MCH	RURAL	EFPA	CSI	P PHYS	TOTAL
N	438	440	1457	479	454	1442	4710
<i>Percentage</i>							
No Occupation beside Housework	82.0	83.4	75.1	69.7	74.9	69.6	74.2
Have an Occupation	18.0	16.6	24.9	30.3	25.1	30.4	25.8
N HAVING AN OCCUPATION	<u>79</u>	<u>73</u>	<u>363</u>	<u>145</u>	<u>114</u>	<u>439</u>	<u>1213</u>
<i>Percentage</i>							
High Professional/Managerial	6.3	2.7	3.6	17.2	23.7	36.9	19.3
Intermed /Tech./Administrative	24.0	39.7	32.5	53.1	42.1	45.8	40.6
Clerical	1.3	---	1.4	2.8	0.9	1.4	1.4
Trading	1.3	1.4	1.4	1.4	3.5	---	1.1
Skilled Labor	11.4	16.4	8.5	4.8	6.1	6.6	7.8
Unskilled Labor	24.0	5.5	14.0	9.0	9.6	5.0	10.0
Farming	17.7	30.1	28.6	9.6	9.6	2.7	14.6
Agricultural/Casual Labor	13.9	4.1	9.9	1.4	4.4	1.6	5.3
Unemployed	---	---	---	0.7	---	---	0.1

TABLE 16
CLIENTS ACCORDING TO LEVEL OF HUSBAND'S EDUCATION

HUSBAND'S EDUCATION LEVEL	HOSP	MCH	RURAL	EFPA	CSI	P PHYS	TOTAL
N	438	440	1457	479	454	1442	4710
<i>Percentage</i>							
Illiterate	42.5	39.3	42.3	25.9	24.0	16.6	30.8
Read & Write	16.9	20.0	19.8	15.2	15.4	8.7	15.3
Primary	5.5	7.3	5.7	5.4	3.3	5.2	5.4
Preparatory	8.4	5.2	5.7	7.3	4.6	4.9	5.7
Secondary	18.5	18.2	18.9	22.5	27.8	26.8	22.5
College	2.1	3.2	2.4	3.8	4.8	7.4	4.3
University	5.9	6.8	5.1	18.6	19.6	29.4	15.6
No Answer	0.2	---	---	1.3	0.4	0.9	0.5

TABLE 17
PERCENTAGE DISTRIBUTION OF SAMPLED CLIENTS BY HUSBANDS' OCCUPATION BY SDP

OCCUPATION	HOSP	MCH	RURAL	EFPA	CSI	P PHYS	TOTAL
N	438	440	1457	479	454	1442	4710
<i>Percentage</i>							
High Profes /Manag in Govt.	5.0	5.5	4.5	14.6	14.1	18.0	10.7
High Profes /Manag in Private	0.9	1.4	0.6	2.9	5.3	9.0	4.0
Interm Tech/Admin in Govt	9.8	9.3	13.8	14.4	16.5	15.5	13.9
Interm. Tech/Admin in Private	0.2	2.3	0.8	1.9	2.6	4.9	2.4
Clerical/Manual in Govt.	23.5	21.4	20.4	15.7	11.0	10.4	16.3
Clerical/Manual in Private	32.4	37.3	22.8	32.8	26.4	21.6	26.0
Trading	4.6	4.3	2.2	5.2	7.9	8.8	5.5
Farming	10.0	9.8	20.0	4.6	7.5	6.1	11.1
Agriculture/Casual Labor	10.5	8.2	14.4	6.3	7.5	3.9	8.7
Unemployed/Incapacitated	3.0	0.7	0.6	1.7	1.1	1.7	1.3

TABLE 18
CLIENTS ACCORDING TO HOUSING SIZE AND CHARACTERISTICS

	HOSP	MCH	RURAL	EFPA	CSI	P PHYS	TOTAL
N	438	440	1457	479	454	1442	4710
NUMBER OF INDIV /HH (% with)							
< 3 persons	2 1	2 7	1 2	2 1	5 7	23 9	8 9
3 - 4 persons	20 8	30 0	16 1	29 0	33 3	38 4	27 6
5 - 7 persons	49 8	47 5	46 8	52 0	40 5	28 4	41 4
8 - 10 persons	18 0	14 5	23 0	11 7	13 7	6 7	14 7
11 persons +	9 4	5 2	12 8	5 2	6 8	2 6	7 3
Avg (persons)	6 63	5 85	7 34	5 86	5 86	4 41	5 94
S D (persons)	3 15	2 57	3 71	2 60	3 23	2 68	3 31
NUMBER OF ROOMS (% with)							
0 - 2 rooms	19 6	19 5	12 9	15 4	8 8	7 1	12 2
3 - 4 rooms	57 3	64 5	50 9	66 2	61 5	69 2	61 0
5 rooms +	23 1	15 9	36 2	18 4	29 7	23 7	26 8
Avg (rooms)	3 80	3 51	4 46	3 78	4 24	4 06	4 10
S D (rooms)	2 21	1 74	2 46	1 97	2 11	1 85	2 14
AVG DENSITY PER ROOM							
S D (persons/rooms)	2 12	1 94	1 87	1 84	1 53	1 19	1 66
	1 34	1 31	0 97	1 25	0 99	0 78	1 08
SOURCE OF LIGHTING (% with)							
Electricity	92 9	95 7	92 4	98 1	98 7	98 8	95 9
Kerosene	7 1	4 3	7 2	1 5	1 1	1 1	3 9
Other	---	---	0 4	0 4	0 2	0 1	0 2
SOURCE OF DRINK WATER (% with)							
Tap inside house	62 1	65 5	48 9	81 0	77 5	86 5	69 2
Tap outside house	13 0	16 6	15 6	6 9	7 7	4 4	10 4
Pump inside house	7 1	5 2	13 5	4 4	5 7	3 9	7 5
Pump outside house	16 2	10 0	20 5	6 5	8 6	4 7	11 7
Open well	0 5	0 7	0 2	---	0 2	---	0 2
River/canal	0 5	---	0 3	---	---	0 1	0 1
Water vehicle/water carrier	0 7	2 0	1 0	1 3	0 2	0 4	0 8
TYPE OF LATRINE (% with)							
Flush WC - with sewage system	34 5	42 3	12 7	58 2	55 9	69 0	43 5
Flush WC - without sewage system	2 7	5 2	2 3	2 3	2 0	2 3	2 6
Private latrine with septic tank	43 6	39 8	67 6	31 3	35 7	24 1	42 1
Pit type latrine	11 9	5 2	10 1	5 8	5 1	2 8	6 7
Common latrine inside house	1 6	2 5	0 6	1 5	0 4	0 4	0 9
Public latrine	0 2	2 0	1 4	0 6	0 2	0 2	0 8
In the open	2 7	2 5	4 9	---	0 7	0 7	2 3
Other	2 7	0 5	0 3	0 2	---	0 4	0 6

TABLE 19
CLIENTS ACCORDING TO OWNERSHIP OF HOUSEHOLD DURABLE GOODS AND MEANS OF TRANSPORT

	HOSP	MCH	RURAL	EFPA	CSI	P PHYS	TOTAL
N	438	440	1457	479	454	1442	4710
<i>Percent Who Own</i>							
Washing Machine	70.5	78.2	66.5	87.3	90.1	91.3	80.0
Gas Cooker Oven	51.4	59.5	39.4	75.4	76.2	85.5	63.7
Refrigerator	44.5	48.9	38.2	71.4	70.3	80.7	59.3
Water Heater	13.2	15.2	6.6	38.0	36.6	51.6	27.9
Radio	78.1	79.8	77.8	82.9	90.3	93.6	84.6
TV (black & white)	48.9	55.2	56.8	46.3	44.3	35.7	47.2
TV (color)	26.5	25.5	18.9	49.1	48.5	63.5	39.8
Video Recorder	2.7	3.4	1.6	10.0	11.2	19.6	9.2
Sewing Machine	17.8	14.8	14.6	25.7	25.3	24.5	20.1
Electric Fan	42.9	45.7	40.8	65.1	66.5	71.7	55.9
Air Conditioner	0.9	0.9	0.3	1.9	0.7	4.5	1.9
Telephone	4.3	4.3	2.3	16.3	15.2	24.5	12.1
Private Car	2.5	4.1	2.1	6.7	8.8	15.5	7.5
Goods Transport Vehicle	1.1	1.4	1.6	1.5	1.3	2.0	1.6
Motorcycle	4.3	3.0	3.2	1.5	4.6	2.3	3.0
Bicycle	13.2	13.9	18.1	17.3	16.3	11.6	15.0

TABLE 20
CLIENTS ACCORDING TO OWNERSHIP OF LAND, BUILDINGS, MACHINERY & ANIMALS

	HOSP	MCH	RURAL	EFPA	CSI	P PHYS	TOTAL
N	438	440	1457	479	454	1442	4710
<i>Percent Who Own.</i>							
Agricultural land	18.7	19.8	35.8	15.0	23.8	18.2	24.1
Other land	1.8	2.3	3.2	3.5	5.1	3.3	3.2
Housing buildings	58.7	55.7	77.8	50.3	57.5	42.2	58.3
Commercial buildings	5.7	5.5	4.2	7.3	10.6	11.2	7.5
Empty buildings	0.7	---	1.7	1.5	2.0	0.9	1.2
Agricultural machinery	2.1	1.4	5.1	1.7	3.3	2.7	3.2
Animals/cattle	17.6	13.9	34.0	9.2	16.7	10.7	19.3

TABLE 21
CLIENTS ACCORDING TO HOUSEHOLD MONTHLY INCOME

	HOSP	MCH	RURAL	EFPA	CSI	P PHYS	TOTAL
N	438	440	1457	479	454	1442	4710
MONTHLY INCOME (% with)	10 0						
< 100 LE	25 8	5 2	9 1	4 8	4 8	3 8	6 3
LE 100 -	26 3	31 8	26 7	20 9	15 4	13 2	21 3
LE 200 -	28 8	28 0	25 3	23 4	24 4	21 7	24 3
LE 300 -	6 8	27 7	28 8	32 4	35 5	36 3	32 0
LE 500 -	1 4	4 8	6 8	12 9	10 6	14 1	9 8
LE 700 -	0 9	1 4	1 9	3 8	3 5 5 7	4 2	2 8
LE 1000+	263 8	1 1	1 4	1 9	383 3	6 8	3 5
Avg Monthly Inc (LE)	171 1	258 2	270 5	329 7	403 0	422 8	332 4
S D (LE)		208 6	190 8	312 7		466 4	339 5

TABLE 22
CLIENTS ACCORDING TO HOUSEHOLD MONTHLY EXPENDITURE

	HOSP	MCH	RURAL	EFPA	CSI	P PHYS	TOTAL
N	438	440	1457	479	454	1442	4710
MONTHLY EXPENDITURE (% with)							
< 100 LE	8 2	6 4	8 3	4 8	3 1	3 4	5 8
LE 100 -	26 7	35 0	30 5	23 8	20 0	16 1	24 5
LE 200 -	31 1	29 8	27 0	25 7	26 7	24 1	26 6
LE 300 -	27 9	24 5	26 4	32 2	33 3	39 4	31 6
LE 500 -	4 8	3 4	6 1	11 1	11 9	11 3	8 4
LE 700 -	0 9	0 5	0 8	1 7	1 3	2 2	1 4
LE 1000+	0 5	0 5	0 9	0 8	3 7	3 5	1 9
Avg Monthly Exp (LE)	246 0	226 0	246 6	284 5	315 6	331 9	281 3
S D (LE)	144 5	141 5	159 0	180 4	193 9	231 3	191 3

TABLE 23
SELECTED REPRODUCTIVE INDICATORS OF CLIENTS

SELECTED INDICATORS	HOSP	MCH	RURAL	EFPA	CSI	P PHYS	TOTAL
NO OF MARRIED CLIENTS	438	440	1457	478	453	1436	4702
<i>Average No of</i>							
Pregnancies	4 6	3 9	4 6	4 0	3 7	2 6	3 8
Live Births	4 1	3 4	4 1	3 5	3 3	2 0	3 3
Surviving Children	3 5	3 0	3 6	3 2	2 9	1 7	2 8
N OF CLIENTS WITH PREG LOSS	<u>151</u>	<u>132</u>	<u>434</u>	<u>151</u>	<u>136</u>	<u>514</u>	<u>1518</u>
% from Total	34 5	30 0	29 8	31 6	30 0	35 8	32 3
Avg No of Pregnancy Loss	1 7	1 6	1 6	1 6	1 6	1 8	1 7
N OF CLIENTS WITH DEAD CHILDREN	<u>141</u>	<u>123</u>	<u>495</u>	<u>120</u>	<u>99</u>	<u>227</u>	<u>1205</u>
% from Total	32 2	28 0	34 0	25 1	21 9	15 8	25 6
Avg No of Dead Children	1 8	1 5	1 7	1 5	1 5	1 5	1 6
N	438	440	1457	479	454	1442	4710
<i>Percentage</i>							
Never Pregnant	2 5	3 0	3 0	2 3	6 6	22 1	9 1
With No Live Births	3 2	3 9	3 4	2 7	7 7	29 7	11 8
With No Surviving Children	3 7	4 3	3 8	2 9	8 1	31 1	12 5
Currently Pregnant	5 9	9 3	11 3	5 8	11 0	38 6	18 4
CONTRACEPTIVE USE (<i>Percentage</i>)							
Current Users	67 6	82 3	78 3	78 7	71 4	24 4	60 6
Former Users	18 5	10 5	11 2	14 0	16 5	29 0	18 0
Never Users	13 9	7 3	10 5	7 3	12 1	46 6	21 4
N OF CURRENT USERS	296	362	1141	377	324	352	2852
<i>Percentage</i>							
Intends to Continue Use	70 9	78 5	76 8	81 2	75 6	74 1	76 5
Does Not Intend to Continue Use	10 1	5 8	11 4	5 3	7 7	10 5	9 2
Does Not Know	18 9	15 7	11 8	13 5	16 7	15 3	14 3

TABLE 24
SELECTED INDICATORS OF CONTRACEPTIVE USE DURING THE OPEN BIRTH INTERVAL

	HOSP	MCH	RURAL	EFPA	CSI	P PHYS	TOTAL
N WITH OPEN INTERVAL	427	427	1413	467	423	1117	4274
N WHO USED CONTRA DURING INTERVAL	<u>365</u>	<u>401</u>	<u>1268</u>	<u>433</u>	<u>391</u>	<u>700</u>	<u>3558</u>
<i>Average</i>							
Number of Contraceptives Used	1 6	1 7	1 7	1 8	1 7	1 4	1 6
Duration of Interval (Month)	33 7	29 8	34 6	40 1	31 1	34 7	34 3
Duration of Use (Month)	27 1	25 1	29 1	35 9	23 7	32 3	29 3
IUD USERS DURING INTERVAL (N=)	<u>288</u>	<u>348</u>	<u>631</u>	<u>319</u>	<u>289</u>	<u>516</u>	<u>2391</u>
Incidents* of Use	359	428	756	436	344	615	2938
Ratio	1 2	1 2	1 2	1 4	1 2	1 2	1 2
PILL USERS DURING INTERVAL (N=)	<u>131</u>	<u>165</u>	<u>888</u>	<u>192</u>	<u>146</u>	<u>257</u>	<u>1779</u>
Incidents of Use	140	198	1262	259	165	272	2296
Ratio	1 1	1 2	1 4	1 3	1 1	1 1	1 3
INJECTION USERS DURING INTERVAL (N=)	<u>65</u>	<u>16</u>	<u>25</u>	<u>33</u>	<u>96</u>	<u>38</u>	<u>273</u>
Incidents of Use	79	22	27	39	124	41	332
Ratio	1 2	1 4	1 1	1 2	1 3	1 1	1 2
CONDOM USERS DURING INTERVAL (N=)	<u>7</u>	<u>8</u>	<u>25</u>	<u>14</u>	<u>24</u>	<u>31</u>	<u>109</u>
Incidents of Use	7	9	31	19	28	31	125
Ratio	1 0	1 1	1 2	1 4	1 2	1 0	1 1

* Incident refers to an uninterrupted period of use of a method

TABLE 25
CLIENTS THAT USED SELECTED CONTRACEPTIVES AND COMPLETED INCIDENT OF USE
AND AVERAGE DURATION OF USE

	HOSP	MCH	RURAL	EFPA	CSI	P PHYS	TOTAL
IUD (N=)	<u>126</u>	<u>109</u>	<u>271</u>	<u>150</u>	<u>113</u>	<u>322</u>	<u>1091</u>
Incidents of Use	149	131	317	195	134	371	1297
Avg Duration of Use (Months)	31 5	29 0	25 0	28 7	25 3	28 5	27 7
PILL (N=)	<u>110</u>	<u>140</u>	<u>524</u>	<u>149</u>	<u>123</u>	<u>192</u>	<u>1238</u>
Incidents of Use	113	153	597	162	133	197	1355
Avg Duration of Use (Months)	16 0	20 1	21 6	29 3	18 4	24 8	22 0
INJECTION (N=)	<u>32</u>	<u>11</u>	<u>19</u>	<u>14</u>	<u>58</u>	<u>28</u>	<u>161</u>
Incidents of Use	34	12	20	15	58	29	168
Avg Duration of Use (Months)	6 7	7 2	10 5	8 0	11 1	10 8	9 5
CONDOM (N=)	<u>3</u>	<u>5</u>	<u>18</u>	<u>11</u>	<u>17</u>	<u>19</u>	<u>72</u>
Incidents of Use	3	5	18	11	17	19	73
Avg Duration of Use (Months)	23 0	27 0	4 3	30 0	8 4	18 6	15 2
ALL METHODS (N=)	<u>226</u>	<u>217</u>	<u>676</u>	<u>264</u>	<u>228</u>	<u>480</u>	<u>2091</u>
Incidents of Use	303	303	970	385	345	630	2936
Avg Duration of Use (Months)	22 5	23 4	21 9	28 0	19 4	26 4	23 6

TABLE 26
CLIENTS ACCORDING TO TRAVEL MODE, TRAVEL TIME, TRANSPORT TYPE & COST

	HOSP	MCH	RURAL	EFPA	CSI	P PHYS	TOTAL
N	413	413	1289	440	408	1441	4404
TRAVEL MODE (% who)							
Go On Foot	17.2	48.7	88.4	66.6	38.2	33.7	53.3
Use Transport	82.8	51.3	11.6	33.4	61.8	66.3	46.7
TRAVEL TIME (% who take)							
0 - 5 min	3.4	10.4	18.9	16.6	9.1	9.1	12.3
6 - 15 min	31.2	42.9	56.7	47.7	40.4	40.1	45.2
16 - 30 min	39.0	29.1	20.9	23.9	30.4	30.5	27.7
31 - 60 min	21.3	14.3	2.9	10.0	14.2	15.5	11.6
60+ min	5.1	3.4	0.5	1.8	5.9	4.7	3.2
Avg Travel Time (min)	31.6	25.4	15.7	20.7	27.7	26.6	23.3
S D (min)	21.3	20.2	11.8	17.7	22.9	21.4	19.5
N WHO USE TRANSPORT	342	212	150	147	252	955	2058
TYPE OF TRANSPORT (% who use)							
Mimbus	80.7	82.1	78.7	59.1	80.6	49.8	64.8
Public Bus	12.9	11.3	7.3	28.6	5.2	12.1	12.1
Private Taxi	2.9	3.8	0.7	3.4	8.3	19.9	11.4
Private Car	0.9	---	3.3	5.4	3.6	15.0	8.2
Train	2.3	2.8	1.3	2.7	2.4	2.4	2.4
Other	0.3	---	8.7	0.7	---	0.7	1.1
COST OF TRANSPORT (% with cost)							
< 50 PT	33.7	64.2	95.1	77.3	55.6	53.4	67.3
50 - 100 PT	60.3	30.3	4.5	18.9	33.6	26.7	23.5
101 - 300 PT	5.1	5.1	0.2	3.6	9.3	14.3	6.9
301+ PT	1.0	0.5	0.2	0.2	1.5	5.6	2.2
Avg (PT)	72.2	70.1	46.7	76.9	91.5	151.4	106.9
S D (PT)	79.3	57.7	54.3	60.8	121.4	184.5	141.7

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TABLE 27
CLIENTS ACCORDING TO WAITING TIME, WAITING PLACE & ORGANIZATION OF SERVICES

	HOSP	MCH	RURAL	EFPA	CSI	P PHYS	TOTAL
N	413	413	1289	440	408	1441	4404
WAITING TIME (% who spent)							
0 - 5 min	16.9	17.4	34.4	27.5	27.0	14.9	23.4
6 - 15 min	35.1	36.3	43.4	32.7	38.7	33.1	37.1
16 - 30 min	24.7	30.5	15.4	25.0	23.8	30.6	24.4
31- 60 min	15.7	11.4	5.0	10.9	9.3	13.9	10.5
61+ min	7.5	4.4	1.8	3.9	1.2	7.6	4.6
Avg (min)	27.9	24.4	15.4	21.7	18.7	28.0	22.5
S D (min)	25.5	21.9	16.6	21.1	16.9	24.9	22.1
WAITING PLACE (% in)							
Waiting Room/Hall	62.2	77.5	39.6	61.1	98.8	98.5	72.2
Courtyard	11.1	6.8	30.3	9.8	---	0.3	11.6
Corridor	22.8	12.3	22.0	16.6	---	0.3	11.5
Nurse/Soc Worker's Room	1.5	---	0.3	9.1	---	---	1.1
Other	---	0.2	0.6	0.5	---	---	0.3
Did Not Wait	2.4	3.1	7.3	3.0	1.2	0.8	3.3
WAITING CONDITIONS (% who)							
Sat on a Chair	69.5	83.3	50.3	81.8	97.1	99.0	81.1
Stood/Other	28.1	13.6	43.4	15.2	0.9	0.3	15.6
Sat on the Floor	2.4	3.1	6.3	3.0	2.0	0.8	3.3
ORG OF SERVICES (% who said)							
"First come, first served"	90.8	92.0	87.0	93.9	93.9	98.5	92.9
No Order	5.1	5.1	5.7	2.7	0.7	0.4	3.1
Don't Know	4.1	2.9	7.2	3.4	5.4	1.0	4.0

TABLE 28
FP CLIENTS (FIRST & REPEAT VISIT) BY SERVICE RECEIVED,
AVERAGE COST & TYPE OF SDP

	HOSP	MCH	RURAL	EPPA	CSI	P PHYS	TOTAL
TOTAL PAYING CLIENTS (N=)	255	246	899	280	255	191	2126
Avg Cost (PT)	236	168	78	280	832	1200	325
NON-PAYING CLIENTS (N=)	26	109	163	64	57	67	476
RECEIVED OC PILLS (N=)	<u>13</u>	<u>36</u>	<u>610</u>	<u>68</u>	<u>14</u>	<u>11</u>	<u>752</u>
Avg Cost (PT)	135	27	23	39	388	532	41
S D	89	29	34	67	248	430	106
RECEIVED IUDs (N=)	<u>99</u>	<u>157</u>	<u>133</u>	<u>70</u>	<u>68</u>	<u>48</u>	<u>575</u>
Avg Cost (PT)	295	224	315	527	1423	2779	649
S D	123	65	199	181	1174	2208	1061
RECEIVED INJECT (N=)	<u>44</u>	<u>6</u>	<u>2</u>	<u>22</u>	<u>61</u>	<u>5</u>	<u>140</u>
Avg Cost (PT)	413	375	193	623	1001	970	717
S D	103	42	223	117	742	358	570
RECEIVED CONDOM/FOAM TABLETS (N=)	<u>4</u>	<u>7</u>	<u>20</u>	<u>7</u>	<u>10</u>	<u>1</u>	<u>49</u>
Avg Cost (PT)	171	72	41	78	396	2500	184
S D	95	88	24	58	282	0	388
IUD REMOVAL (N=)	<u>11</u>	<u>8</u>	<u>12</u>	<u>7</u>	<u>9</u>	<u>11</u>	<u>58</u>
Avg Cost (PT)	137	53	99	29	533	811	326
S D	134	62	93	148	387	478	365
IUD FOLLOW-UP (N=)	<u>57</u>	<u>27</u>	<u>94</u>	<u>87</u>	<u>77</u>	<u>74</u>	<u>416</u>
Avg Cost (PT)	106	72	97	211	325	686	267
S D	62	73	123	122	140	555	332
CONSULT'N RECEIVED NO METHOD (N=)	<u>27</u>	<u>5</u>	<u>28</u>	<u>19</u>	<u>16</u>	<u>41</u>	<u>136</u>
Avg. Cost (PT)	106	37	84	211	981	558	353
S D	61	19	105	141	1778	396	705

TABLE 29
NON-FP CLIENTS, BY AVERAGE COST OF SERVICE RECEIVED

	HOSP	MCH	RURAL	EFPA	CSI	P PHYS	TOTAL
PREGNANCY MONITORING (N=)	<u>18</u>	<u>34</u>	<u>137</u>	<u>22</u>	<u>39</u>	<u>556</u>	<u>806</u>
Avg Cost (PT)	46	33	29	333	428	710	527
S D	25	93	54	623	276	945	844
GYNECOLOGIC EXAM (N=)	<u>58</u>	<u>11</u>	<u>41</u>	<u>35</u>	<u>24</u>	<u>296</u>	<u>465</u>
Avg Cost (PT)	76	41	72	185	843	733	541
S D	56	38	134	104	1657	776	782
LAB INVESTIGATION (N=)	<u>7</u>	<u>3</u>	<u>8</u>	<u>5</u>	<u>19</u>	<u>22</u>	<u>64</u>
Avg Cost (PT)	130	183	11	320	645	807	518
S D	207	318	11	383	253	823	594
STERILITY TREATMENT (N=)	<u>9</u>	<u>1</u>	<u>3</u>	<u>3</u>	<u>10</u>	<u>133</u>	<u>159</u>
Avg Cost (PT)	64	50	23	233	420	1157	1003
S D	38	0	25	58	602	1456	1385
OTHER TREATMENT (N=)	<u>40</u>	<u>9</u>	<u>36</u>	<u>31</u>	<u>12</u>	<u>174</u>	<u>302</u>
Avg Cost (PT)	76	6	88	292	554	762	512
S D	105	17	187	417	736	1002	846
TOTAL (N=)	<u>132</u>	<u>58</u>	<u>227</u>	<u>96</u>	<u>105</u>	<u>1182</u>	<u>1800</u>
Avg Cost (PT)	74	38	45	262	592	775	570
S D	84	100	105	393	886	992	893

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TABLE 30
CLIENTS BY OPINION ON COST OF SERVICE

	HOSP	MCH	RURAL	EFPA	CSI	P PHYS	TOTAL
RECEIVED FP SERVICE (N=)	<u>281</u>	<u>355</u>	<u>1062</u>	<u>344</u>	<u>302</u>	<u>258</u>	<u>2602</u>
% Who Did Not Pay	9 3	30 7	15 3	18 6	15 6	26 0	18 3
PAID FOR THE SERVICE (N=)	<u>255</u>	<u>246</u>	<u>899</u>	<u>280</u>	<u>255</u>	<u>191</u>	<u>2126</u>
OPINION OF COST <i>Percentage</i>							
Cheap	7 5	23 6	38 0	17 1	4 7	12 0	23 6
Suitable	85 5	75 2	59 7	80 0	78 4	76 4	71 0
Expensive	7 1	1 2	2 2	2 9	16 9	11 5	5 4
WILLING TO PAY MORE (N=)	<u>24</u>	<u>29</u>	<u>145</u>	<u>37</u>	<u>34</u>	<u>19</u>	<u>288</u>
% From Total Who Paid	9 4	11 8	16 1	13 2	13 3	9 9	11 1
Average Suggested Increase (PT)	298	353	140	253	440	1240	270
RECEIVED NON FP SERVICE (N=)	<u>132</u>	<u>58</u>	<u>227</u>	<u>96</u>	<u>105</u>	<u>1182</u>	<u>1800</u>
% Who Did Not Pay	8 3	70 7	48 9	18 8	19 0	30 7	31 3
PAYING NON FP CLIENTS (N=)	<u>121</u>	<u>17</u>	<u>116</u>	<u>78</u>	<u>85</u>	<u>819</u>	<u>1236</u>
OPINION OF COST <i>Percentage</i>							
Cheap	14 0	17 6	29 3	25 6	5 9	6 8	10 9
Suitable	74 4	64 7	69 0	73 1	82 4	80 9	78 5
Expensive	11 6	17 6	1 7	1 3	11 8	12 2	10 5
WILLING TO PAY MORE (N=)	<u>8</u>	<u>1</u>	<u>13</u>	<u>13</u>	<u>6</u>	<u>106</u>	<u>147</u>
% From Total Who Paid	6 6	5 9	5 7	16 7	7 1	12 9	11 9
Average Suggested Increase (PT)	73	100	186	227	633	1084	849

TABLE 31
CLIENTS BY RECEPTION, RECORDING & INFORMATION GIVEN

	HOSP	MCH	RURAL	EFPA	CSI	P PHYS	TOTAL
N	413	413	1289	440	408	1441	4404
<i>Percentage of clients who</i>							
Were received on arrival	87 4	91 5	83 9	92 3	98 0	83 8	87 1
Had their data recorded	53 3	72 2	53 0	60 9	92 4	45 1	56 7
Were briefed on available services	12 6	30 3	27 5	38 2	49 5	29 5	30 1
CLIENT QUERIES							
Had a chance to ask questions	67 1	59 1	45 2	60 2	67 4	82 7	64 4
Had no chance to ask questions	14 5	11 9	17 7	13 9	14 0	7 3	12 7
Had no questions to ask	18 4	29 1	37 2	25 9	18 6	10 1	22 9
N WHO ASKED QUESTIONS	<u>277</u>	<u>244</u>	<u>582</u>	<u>265</u>	<u>275</u>	<u>1191</u>	<u>2834</u>
% received clear & adequate answers	93 5	97 5	97 4	98 5	98 5	99 6	98 2
N REQUIRING FP SERVICES	<u>246</u>	<u>333</u>	<u>1011</u>	<u>329</u>	<u>281</u>	<u>225</u>	<u>2425</u>
% were briefed on available contra	48 4	44 1	63 4	61 4	78 6	59 6	60 4
N BRIEFED ON CONTRACEPTIVES	<u>119</u>	<u>147</u>	<u>641</u>	<u>202</u>	<u>221</u>	<u>114</u>	<u>1464</u>
% got a clear idea on each contra	82 4	87 8	89 2	87 1	91 9	92 5	88 9

TABLE 32
CLIENTS BY PROCEDURE OF SELECTION OF CONTRACEPTIVE & INFO GIVEN ON SELECTED CONTRACEPTIVE

	HOSP	MCH	RURAL	EFPA	CSI	P PHYS	TOTAL
N	246	333	1011	329	281	225	2425
<i>Percentage.</i>							
Physically examined before choice of contra	75 2	81 4	55 1	82 7	95 4	96 9	73 0
Lab investigation performed	7 7	8 1	15 3	15 5	73 7	14 4	21 2
CONTRACEPTIVE SELECTED. (% were)							
By client alone	64 6	60 7	59 6	45 3	43 8	40 0	54 7
By physician alone	9 7	26 1	28 4	40 7	34 2	40 0	31 6
By client & physician jointly	5 7	12 9	11 0	13 7	21 7	19 6	13 1
IUD WAS SELECTED	73 2	83 2	34 2	64 4	67 6	79 6	57 1
N OF IUD USERS	<u>180</u>	<u>277</u>	<u>346</u>	<u>212</u>	<u>190</u>	<u>179</u>	<u>1348</u>
% Clients briefed on checking presence of IUD	76 7	85 9	90 5	92 9	92 1	91 1	88 4
N OF USERS OF OTHER CONTRACEPTIVES	<u>66</u>	<u>56</u>	<u>665</u>	<u>117</u>	<u>91</u>	<u>46</u>	<u>1041</u>
% Clients briefed on correct method of use	75 8	85 7	72 9	68 4	84 6	97 8	75 4
N OF ALL USERS	<u>246</u>	<u>333</u>	<u>1011</u>	<u>329</u>	<u>281</u>	<u>225</u>	<u>2425</u>
% Users briefed on possible side-effect/compl	58 5	70 6	64 9	74 8	76 4	86 7	69 7
% Users told they could change to another contraceptive if a problem arises	39 4	46 5	52 2	52 3	61 6	63 1	52 2
N BRIEFED OF SIDE EFFECTS/COMPLIC	<u>144</u>	<u>235</u>	<u>656</u>	<u>246</u>	<u>215</u>	<u>195</u>	<u>1689</u>
% Clients told how to act if side-effects or complications occurred	85 4	93 2	90 2	88 2	95 8	94 4	91 1

TABLE 33
CLIENTS BY SERVICE TIME, WORKING HOURS & SCHEDULING OF REVISITS

	HOSP	MCH	RURAL	EFPA	CSI	P PHYS	TOTAL
N OF ALL CLIENTS	413	413	1289	440	408	1441	4404
<i>Percentage</i>							
Time with phys considered adequate	88 1	84 5	55 7	82 3	92 6	99 2	81 7
Total time spent at SDP considered							
Reasonable	81 1	85 2	91 9	91 8	91 7	85 1	88 0
Too long	16 9	13 3	6 4	6 8	6 1	14 3	10 6
Too short	1 9	0 7	1 5	1 4	2 2	0 6	1 2
SDP working days considered suitable	99 3	98 5	99 0	97 0	99 3	98 8	98 8
SDP daily work hrs considered suitable	98 8	98 1	98 8	94 8	98 0	97 2	97 7
N REQUIRING FP SERVICE	<u>246</u>	<u>333</u>	<u>1011</u>	<u>329</u>	<u>281</u>	<u>225</u>	<u>2425</u>
Revisit was scheduled	52 4	36 9	25 7	43 2	70 5	50 7	39 8
N OF REVISITS SCHEDULED	<u>129</u>	<u>123</u>	<u>260</u>	<u>142</u>	<u>198</u>	<u>114</u>	<u>966</u>
% Chents believe that someone from SDP will contact her if she missed revisit	3 1	9 8	29 2	16 9	15 2	10 5	16 4
N INTENDING TO CONTIN USE OF SDP	<u>279</u>	<u>350</u>	<u>1038</u>	<u>341</u>	<u>296</u>	<u>253</u>	<u>2557</u>
% From Total FP Client	99 3	98 6	97 7	99 1	98 0	98 1	98 3

TABLE 34
CLIENTS ACCORDING TO RECALL/KNOWLEDGE AND USE OF OTHER SDP'S

TYPE OF SDP	NOT MENTIONED	MENTIONED BUT NOT USED	MENTIONED & USED
N	4710	4710	4710
<i>Percentage</i>			
General Hospital	57.3	37.2	5.5
MCH	73.2	20.7	6.1
Rural Health Unit/Centers	86.3	10.6	3.1
EFPA	92.8	5.2	2.1
CSI	63.3	32.3	4.4
Private Physician	55.0	25.1	19.9
Pharmacy	78.2	2.0	19.9

TABLE 35
CLIENTS INTENTION TO CONTINUE GETTING SERVICE AT THE SDP
& REASONS FOR INTENDING TO DISCONTINUE USING THE SDP

INTENTION	HOSP	MCH	RURAL	EFPA	CSI	P PHYS	TOTAL
N	426	430	1406	470	443	1441	4616
<i>INTEND TO CONTINUE Percentage</i>							
Yes	97.4	98.1	95.8	96.8	95.5	97.5	96.8
No	2.3	1.9	4.2	3.2	4.3	2.5	3.2
Undecided	0.3	---	---	---	0.2	---	0.0
N. DISCONTINUING SERVICE	10	8	59	15	20	36	148
<i>REASONS (% who are)</i>							
Dissatisfied With Service	70.0	62.5	23.7	26.7	45.0	11.1	29.1
Do Not Need Service	10.0	25.0	20.4	26.7	35.0	38.9	27.0
Unavailability of Service	---	12.5	33.9	6.7	---	---	14.9
Going Away	10.0	---	1.7	13.3	5.0	27.8	10.1
Other	10.0	---	20.3	26.6	15.0	22.2	18.9

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TABLE 36
MOST FREQUENTLY MENTIONED REASONS FOR LEAVING AN SDP*

REASONS FOR LEAVING	HOSP	MCH	RURAL	EFPA	CSI	P PHYS	PHAR**
NO OF SHIFTS FROM SDP	525	307	318	192	223	1012	950
<i>Percentage</i>							
Inaccessibility of Site	35.2	27.0	13.5	33.8	40.4	24.2	5.3
Side-Effects/Complications	26.7	32.9	31.4	28.1	24.7	24.6	41.6
Incompetence of Service Providers	11.8	6.8	10.1	7.8	9.4	7.2	0.2
Negligence/Disrespect/III-treatment	11.8	9.8	7.5	3.1	4.0	2.9	0.2
Dissatisfaction with Method	6.5	11.4	11.0	6.8	11.2	8.6	16.4
High Cost of Service	4.6	2.3	3.8	13.0	26.9	38.9	3.3
Irregular Availability of Method	3.6	1.3	11.0	3.1	0.4	2.5	1.5
No Examination	2.1	2.9	9.1	0.5	0.4	0.6	47.3

* These percentages do not add to 100 percent as they represent the frequency that a reason was given by clients for leaving a particular SDP in relation to the number of times such an SDP was left

** Pharmacies are included as they are mentioned as a place where clients have obtained services, however pharmacies are not part of the sampled SDPs

TABLE 37
NONSHIFTERS AND SHIFTERS AND NUMBER OF SHIFTS MADE

STATUS	HOSP	MCH	RURAL	EFPA	CSI	P PHYS	TOTAL
N. OF CLIENTS	438	440	1457	479	454	1442	4710
Nonshifters	36.3	46.6	55.9	45.7	35.2	58.4	50.9
Shifters	63.7	53.4	44.1	54.3	64.8	41.6	49.1
N OF SHIFTERS	279	235	643	260	294	600	2311
One Shift	57.3	63.4	60.8	66.9	58.2	65.2	62.1
Two Shifts	27.2	28.5	27.8	22.7	28.9	24.3	26.5
Three or More Shifts	15.6	8.1	11.4	10.4	12.9	10.5	11.4
Avg Shifts	1.6	1.5	1.5	1.4	1.6	1.5	1.5

TABLE 38
MOVEMENTS FROM AND TO THE VARIOUS SDP'S

	N SHIFTS FROM	N SHIFTS TO	NET GAIN/LOSS	GROSS MOVEMENT	% FROM TOTAL
Hospital	525	507	-18	1032	14.6
MCH	307	364	57	671	9.5
Rural	318	673	355	991	14.1
EFPA	192	329	137	521	7.4
CSI	223	400	177	623	8.8
Private Phys	1012	982	-30	1994	28.3
Pharmacy	950	272	-678	1222	17.3
Total Shifts	3527	3527	0	7054	100.0

TABLE 39
DISTRIBUTION OF ALL SHIFTS FROM AND TO THE VARIOUS SDP'S

FROM	HOSP	MCH	RURAL	EFPA	CSI	P PHYS	PHAR	TOTAL SHIFTS	% FROM TOTAL
To									
Hospital	65	61	54	31	25	141	130	507	14.4
MCH	63	9	39	15	13	82	143	364	10.3
Rural	94	51	32	42	37	195	222	673	19.1
EFPA	44	38	32	17	20	97	81	329	9.3
CSI	45	25	37	15	9	145	124	400	11.3
P. Phys	156	80	74	57	93	274	248	982	27.9
Pharmacy	58	43	50	15	26	78	2	272	7.7
TOTAL	525	307	318	192	223	1012	950	3527	100.0
% FROM TOTAL	14.9	8.7	9.0	5.4	6.3	28.7	26.9	100	100.0