

IVCD Rehabilitation Initiative Formative Assessment

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Executive Summary

The objective of the IUCD rehabilitation initiative formative assessment was to assess family planning clients' contraceptive preferences and providers' perceptions on the IUCD in four regions in Ethiopia; Addis Ababa, Amhara, Oromiya and SNNP. The aim of the assessment was to provide information to help increase demand for and provision of high quality IUCD services offered by the public sector.

Fifteen facilities were selected to participate in this assessment. All the facilities chosen were receiving capacity building, expendable supplies, commodities and equipment from EngenderHealth and Pathfinder International. Data was collected through interviews with providers and clients and through a facility assessment checklist. A total of 37 providers and 155 clients were interviewed and the checklist was completed at all 15 facilities. Finally, a review of policy documents was conducted in order to examine the policy environment for rehabilitating IUCD use.

Results

The results from the client interviews show little knowledge and very limited use of IUCDs. When asked about what family planning methods they knew of, at least 80% of the clients could name injectables and pills, while less than 60% mentioned IUCDs. Use of injectables and pills was far higher than the IUCD. At the time of the interview, 75% of clients were using injectables and an additional 18% were using pills. Norplant was used by 6% while only 1% were using an IUCD. The most important reasons for choosing their current method was that it has few side effects (32%), it is effective in preventing pregnancy (25%), it is easily available (18%) and it is effective for a long time (12%).

Questions specifically about the IUCD revealed that clients knew very little about it beyond the name. Few clients had seen written information or heard about the IUCD on the radio. Only nine clients said they would consider using the IUCD. Of the 58 who said they would not consider it, the main reason was because they did not know enough about it followed by they do not think it is comfortable.

Provider interviews revealed that only half had received training on IUCD insertion and removal techniques and on IUCD counseling. Most of the providers (62%) had not inserted any IUCDs in the three month period prior to the assessment. About one-fourth inserted only one or two.

Provider knowledge about the IUCD was measured by nine questions. The average score was 4.1 out of nine and surprisingly knowledge scores were similar between the trained and non-trained groups. Attitudes toward the IUCD were also measured through a series of nine statements. In this case, providers who had received training on the IUCD displayed more positive attitudes than those who had not received training with scores of 6.8 vs. 5.6 respectively. The differences in scores between the two groups was even greater in terms of attitudes toward IUCD training. Those trained showed positive attitudes on an average of 8.1 statements vs. 2.4 for those who were not trained.

Service statistics gathered for the facility assessment show that in the three months prior to the assessment, by far most clients were coming for injectables (an average of 770 per clinic), followed by condoms and pills. There was only an average of 3.5 IUCD insertions per clinic. On average, facilities have 57.8 health staff with an average of 2.2 trained in IUCD insertion and removal techniques. Only one clinic did not have any staff trained in IUCD insertions and

removal. Most of the facilities had at least some of the basic materials necessary for IUCD insertions and removals. The equipment missing by the most number of clinics included cotton drawer sheets (7 clinics), dry sterilizers (5), steam sterilizers (5) and towels (4).

Finally the review of policies on family planning shows a favorable policy environment for an initiative to promote IUCD use in Ethiopia. Current policies and the Ethiopian constitution outline fundamental rights that while not specific to the IUCD allow for the provision of IUCD information and high quality service delivery. What is unclear, however, is whether family planning service delivery guidelines including the most current international practices in IUCD service delivery are being effectively disseminated to health care providers.

Discussion

The assessment points to a number of factors that may be contributing to the low use of the IUCD in Ethiopia. First, clients have little knowledge about the method and many have never even heard of it. Second, provider knowledge about the IUCD is weak though attitudes among those trained are essentially positive. Lastly, a lack of trained providers can affect the facilities' abilities to provide the IUCD. These three factors are interrelated and will all need to be addressed in order to increase IUCD use. Finally, it should be noted that the method mix shown in this assessment and in the most recent DHS shows a heavy reliance on injectables and to a lesser extent on pills. Over the long term, this is an expensive mix, one which will not be sustainable without substantial donor input. While IUCDs may seem expensive up front, they are far less expensive than pills and injectables in the long-term.

Recommendations

The following are some of the recommendations that come from this assessment:

1. Promote the IUCD in the community. Clients should be motivated to initiate use and receiving information will be a first step. Satisfied IUCD users could be useful role models for other clients.
2. More providers must be trained at a minimum in basic facts about the IUCD so that they can provide counseling. Training should incorporate current international service delivery guidelines to update provider knowledge. This training may also increase positive attitudes about the IUCD among providers which will come through during client counseling. IUCD counseling should take place at all counseling sessions about methods. Refresher training will be needed periodically.
3. As costs allow, it will be helpful to increase the number of providers trained on insertions and removals. Meanwhile, referral networks can be strengthened. Careful monitoring should also take place of IUCD supplies so that if demand increases, facilities can take care to not run out of equipment and supplies needed to do insertions and removals.
4. Policies and service delivery guidelines should be reviewed and updated as needed to reflect current international knowledge and practices on the IUCD.

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ACRONYMS

DMPA	Depot medroxyprogesterone Acetate
FGAE	Family Guidance Association of Ethiopia
FHD	Family Health Department
FHI	Family Health International
FHI/NC	Family Health International/North Carolina
HIV	Human Immunodeficiency Virus
IPPF	International Planned Parenthood Federation
IUCD	Intrauterine Contraceptive Device
MOH	Ministry of Health
NGO	Non-governmental Organization
SNNP	Southern Nations, Nationalities and Peoples' State
SPSS	Statistical Package for Social Sciences
STI	Sexually Transmitted Infection
TGoE	Transitional Government of Ethiopia
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

I. INTRODUCTION

Ethiopia has a very low contraceptive prevalence rate (8.1%) with high unmet needs (36.9%).¹ The total modern contraceptive use rate among currently married women is 6.3% and the pill and injectables account for 2.5% and 3.1%, respectively. Female sterilization use is at 0.3%. Use of the intrauterine contraceptive device (IUCD) is even lower (0.1%). This poor method mix has a number of drawbacks:

First, women's options for contraception are limited. The two dominant methods (oral contraceptives and injectables), while effective; require regular re-supply. In addition, while these methods are excellent for spacing births, they are not optimal for long-term use for women looking to limit the number of children they have. Second, supply shortages and stock outs have hindered provision and possibly demand for injectable contraceptives.²

Finally, the long-term costs of a method mix heavily skewed toward short-term methods poses a burden on the family planning program. If the current method mix is maintained as contraceptive prevalence in Ethiopia increases, the costs of providing contraception will be unsustainable for the government if donor support should decrease, which currently provides approximately 90 percent of family planning methods.

The Ethiopian population policy acknowledges the limitations of the existing service delivery system in both scope and diversity and encourages creating conditions that will permit users the widest possible choice of contraceptives by diversifying the method mix available in the country. Rehabilitation of the IUCD in Ethiopia addresses these challenges facing the Ethiopian family planning program. The IUCD is highly effective, very safe, and typically has high satisfaction rates among users of the method. Because of its 12-year effectiveness, it can be ideal for those seeking to limit their family size. Despite initial high costs, it is one of the least expensive methods over long time use – by far less expensive than oral contraceptives or injectables. Cost savings to the Ethiopian family planning program from a more balanced method mix could be applied to providing greater access to more contraceptive methods for more Ethiopian women and couples.

Nonetheless, substantial challenges will have to be addressed if the IUCD is to be successfully reintroduced. Work in several countries has indicated that there are several elements that must be addressed including myths and misconceptions, client's knowledge of the method, limited provider skill, facility limitation, and initial cost of service provision.

¹ Ethiopia Demographic and Health Survey 2000. Addis Ababa, Ethiopia and Calverton Maryland: Central Statistical Authority and ORC Macro. May 2001.

² An assessment of reproductive health needs in Ethiopia. Geneva, Switzerland: World Health Organization, 1999.

Objectives

The overall objective of the IUCD rehabilitation initiative formative assessment was to assess family planning clients' contraceptive preferences and providers' perceptions on IUCDs in four regions, Addis Ababa, Amhara, Oromiya, and Southern Nations, Nationalities and Peoples' State (SNNP), in order to increase and sustain access, demand and utilization of high quality IUCD services offered by the public sector.

The specific objectives of the formative assessment were as follows:

1. To understand clients' contraceptive method preferences at public health facilities;
2. To examine provider perspectives on IUCD provision and acceptance;
3. To assess the capacity of implementing health facilities to provide IUCDs; and,
4. To assess the policy environment for rehabilitating IUCD use in the country.

II. METHODOLOGY

The assessment was formative and used rapid assessment techniques. Specifically, this assessment was conducted in public health facilities of the Addis Ababa, Amhara, Oromiya, and SNNP regional states. The selected facilities were those receiving capacity building, expendable supplies, commodities and equipment from EngenderHealth and Pathfinder International.

Study methods

The IUCD rehabilitation initiative formative assessment included face-to-face interviews (with clients and providers), a facility audit and a document review.

a) Client exit interviews

Exit interviews were administered to family planning clients to answer questions about the services that they received. Questions were designed to assess the clients' background characteristics, knowledge of family planning methods, ever and current use of family planning, contraceptive preferences, and perceptions and attitudes towards the IUCD. Clients were also asked about their experiences at the clinic, sources of information, husband approval, reasons for choosing a certain method of contraception, and attitudes towards IUCD use.

b) Provider Interviews

Providers were asked about their socio-demographic characteristics, training related to IUCD insertion and removal, knowledge related to IUCD procedures, their views on client perception toward the IUCD, and availability of supplies. Closed ended questions were used to capture the necessary information to address providers' attitudes and perceptions.

c) Facility checklist

The institutional capacity assessment was conducted using a checklist. This assessment included: the availability of trained manpower, equipment, supplies, examination room, light, and water as related to IUCD provision. As part of the facility assessment, service statistics were collected on contraceptive visits, including IUCD use.

d) Document review

The Family Health International (FHI) Ethiopia Population/Reproductive Health program manager in collaboration with FHI Research to Practice champion examined the policy environment vis-à-vis the IUCD in Ethiopia by reviewing Ministry of Health (MOH) policies and guidelines and studying existing documents. A list of these documents can be found in Appendix #1.

Target population/study sites

A total of 15 public health facilities i.e., hospitals and clinics, were identified by Pathfinder International and EngenderHealth to be included in the study. Of these, eight health facilities (four hospitals and four clinics/health centers) were identified by EngenderHealth; while the remaining seven were selected from Pathfinder International (two hospitals and five clinics/health centers). These facilities were selected from the Addis Ababa, Amhara, Oromiya, and SNNP regions. Though these facilities are situated in urban areas their catchment areas include both urban and rural residents. Therefore, the study population included family planning clients from both urban and rural areas.

Study size and selection

Two to three trained and non-trained family planning providers and about 10 clients were interviewed in each facility. Thus, a total of 37 providers and 155 clients were included in the assessment. Most sites have only one trained IUCD provider; however, the assessment also included other non-trained family planning providers in order to get a wider perspective of providers' perceptions and attitudes towards the IUCD. Those who agreed to be included in the study were selected and interviewed during the assessment. Similarly, each family planning client over the age of 18 was approached as she left the clinic; the first ten who agreed to participate were interviewed. All 15 sites were included in the facility assessment.

Questionnaire preparation

Facility audit, client exit interview, and provider interview forms were drafted by the FHI-Ethiopia office and reviewed and finalized by the Technical Monitor at FHI/North Carolina (FHI/NC). The final forms, specifically the client exit and provider interview forms were translated into local languages (Amharic and Afan Oromo) by consultants. The program officers at the FHI-Ethiopia office supervised the translation and reviewed the translated forms.

a) Pre-test of the instruments

Before initiating the assessment, the forms were pre-tested in Woliso Health Center & Woliso Family Guidance Association of Ethiopia (FGAE) clinic, in South-Western

Shewa Administrative Zone, 120 kms from Addis Abba. Pre-testing; and finalization of the forms was done by the program officers.

b) Training of assistant data collectors

One program officer was responsible for the IUCD formative assessment in the Amhara region and Woreda 17 in Addis; while the other program officer was responsible for data collection in Oromiya, SNNP and Gandhi Memorial Hospital in Addis Ababa. The program officers selected and recruited assistant data collectors at each site. The data collectors' selection criteria were based on educational level (12th grade complete), and knowledge and fluency of the local languages (i.e., Amharic and Afan Oromo) used in the assessment. The assistant data collectors were given a half day training on the techniques of interviewing and the precise meaning of each question in the client exit interview. Program officers were responsible for interviewing providers and completing the facility audit.

Field Work/Data collection

One FHI-Ethiopia program officer and one assistant data collector managed the data collection in the Amhara (team one); and Oromiya and SNNP regions (team two). The field work in the Amhara, Oromiya and SNNP was completed from 21 December 2004-18 January 2005. After that, the assessment of two sites in Addis Ababa was conducted by the program officers and assistant data collectors.

The program officers were responsible for the quality of interviews and facility audit; and checking of questionnaires for missing or inconsistent data.

Data entry and cleaning

After the completion of the field work, open-ended response categories both in the client exit and provider interview forms were summarized and given codes by the program officers before data entry. The program officers also adjusted the data entry format accordingly before encoding the data. The data was entered into the computer using Epi Info version 6.04d.

The data entry screens were created by the FHI program officers and included appropriate range checks and skip patterns. These were reviewed by the data analyst at FHI/NC. The data entry screens were pre-tested to make sure that the error checks were functioning properly. Data entry and cleaning was done by the program officers. Hard copies of the client exit interview, provider interview, and facility audit were stored at the FHI-Ethiopia office.

Data analysis

The data were analyzed at FHI/NC using SPSS version 11. Data analysis was entirely descriptive. Results are presented in the aggregate since the sample was too small to analyze by region. Percentages are given in the tables unless the subgroup is smaller than 20; in which case only the N is presented. Scores were calculated to assess provider knowledge and attitudes toward the IUCD. A correct response to a knowledge question or a positive response to an attitude statement counted as one point toward the total score. Points were summed to calculate each provider's total

knowledge and attitude scores. All tables are found in Appendix 1 while all figures are incorporated into the results presented in the following section.

III. RESULTS

The results are divided into four sections. First, the data from the client interviews is presented. This is followed by the provider interviews and the information obtained from the facility assessments. Finally, a summary of the policy review is presented.

1. Client Interviews

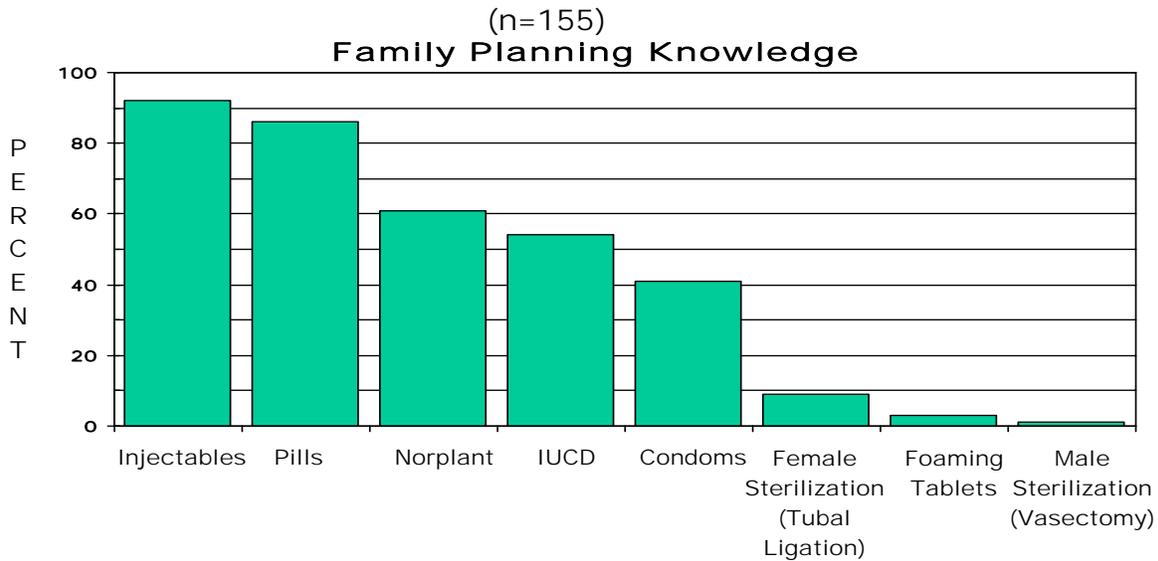
Sociodemographic Characteristics

Most clients came from Amhara and Oromiya regions with the fewest from SNNP and Addis Abada (Table 1). Nearly half were Amhara ethnicity and 26% were Oromo. Over half were Ethiopian Orthodox, one-fourth were Muslim and 19% were Protestant. The average age of the clients interviewed was 28 years with a range of 15 to 45. Almost all were currently married (89%) and only seven percent had never been married. Two-thirds had attended school; of those who had, about half completed grades 1-6 and the other half had completed grade seven or higher. Nearly all respondents had ever given birth and the average number of living children was 3.2 with a range of 1 to 10.

Family Planning Knowledge

When asked which family planning methods they knew of, the ones spontaneously mentioned most often by clients were injectables, pills, Norplant, the IUCD and condoms (Figure 1). Methods mentioned by fewer than 10% of the respondents included female sterilization (9%), foaming tablets (3%), and male sterilization (1%). Only 2 respondents could not name any method.

Figure 1: Family Planning Methods
Mentioned Spontaneously By Clients



Family Planning Counseling and Decisionmaking

When the client first went to the clinic to get a method, she was told about a variety of method options (Table 2). On average, clients said they were told about 3.9 methods. Most were told about injectables and pills and to a lesser extent Norplant. Just half (51%) were told about the IUCD as a contraceptive option. Less than half were told about condoms, female sterilization and male sterilization and very few about foaming tablets.

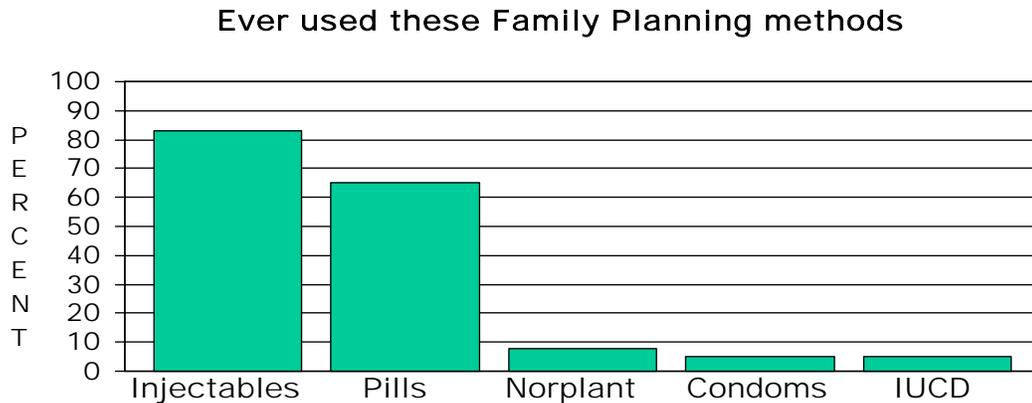
The majority of clients (70%) felt they were given enough information to make a good decision about which method to choose, and 76% felt that the counseling they received helped them to make that decision. More than half (57%) made the decision of which method to use on their own. Of those who said someone helped them to make their decision, the majority said their health professional helped them followed to a lesser extent by the husband or friend or relative. The majority (59%) felt that women are free to choose the method that they want, but 30% feel that providers or counselors tell them which one to chose.

Family Planning Use

The method that had ever been used the most often by client respondents was injectables, followed by pills and to a much lesser extent, Norplant, the IUCD and condoms (Figure 2).

Figure 2: Family Planning Methods Ever Used By Clients

(n=155)

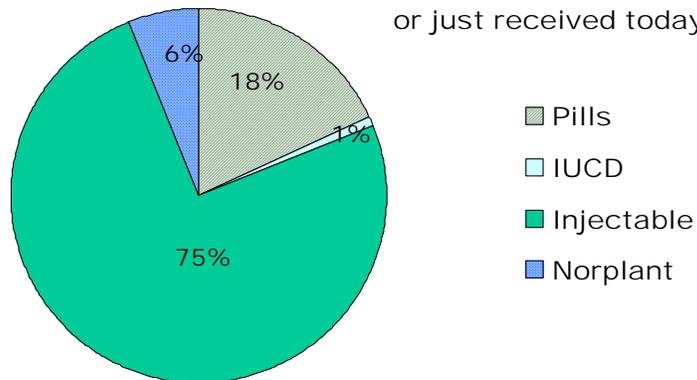


Three-fourths of the clients are currently using injectables with an additional 18% using pills (Figure 3). Only one client is using an IUCD and nine are using Norplant. On average, clients have used their method for close to two years though the majority (63%) has used it for twelve months or less. Most clients (58%) did not know for how long they planned to use their method. Of those who did, on average, clients expect to use their method for 44.6 months with a range of 1-120 months. Injectable users plan to use their method for a longer period of time than pill users (45.2 vs. 36.2 months respectively).

Figure 3: Current Method Use

(n=155)

Which method are you using now, or just received today

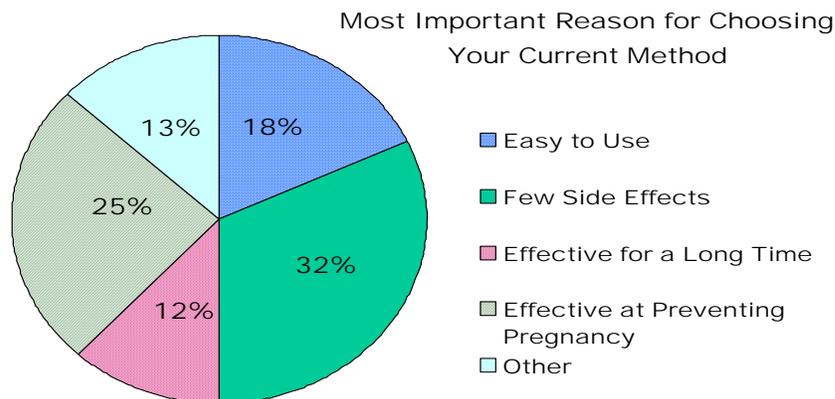


Method Choice

Many factors can affect the contraceptive method a woman chooses including desire for additional children, method attributes, husband approval, preferences of friends and relatives, and rumors about a method. Finally, getting the method desired is important to assess since it can affect method satisfaction and continuation.

For 60%, the main reason they are using family planning is to space births, while for 35% it is to limit births and another 5% has no intention to give birth (Table 4). The most important reasons for choosing their current method was that it has few side effects (32%), it is effective in preventing pregnancy (25%), it is easily available (18%) and it is effective for a long time (12%) (Figure 4).

Figure 4: Reason for Choosing Current Method
(n=155)



Most of the clients (90%) reported that their husband knew they were using their current method and nearly all of them approved of this method. Only nine percent said that they are using methods their husbands do not want them to use. Of the twelve women who reported that, IUCD and Norplant were mentioned by five each, condoms by four and female sterilization and injectables by three each.

Clients reported that injectables (65%) are by far the most preferred family planning method among their friends and relatives. No one said that the IUCD is the most preferred method.

Interestingly, the methods that are most widely used among these respondents, injectables and pills, are also the ones that the most women have heard rumors about. The most women heard rumors about pills (61%) followed by injectables (53%) (Figure 5). Only 14% heard rumors about IUCDs. While rumors about injectables and pills were believed by roughly equal percents of those clients who heard them, the rumors about the pill were more likely to affect choice of a method compared to rumors about injectables (Figures 6 and 7). Only 21 clients heard rumors about IUCDs (Figure 8). Most of these clients did

not believe the rumors affected their choice of method. The majority of clients who heard rumors about any of these methods did not discuss them with their provider.

Figure 5: Heard Rumors about Various Contraceptive Methods (n=155)

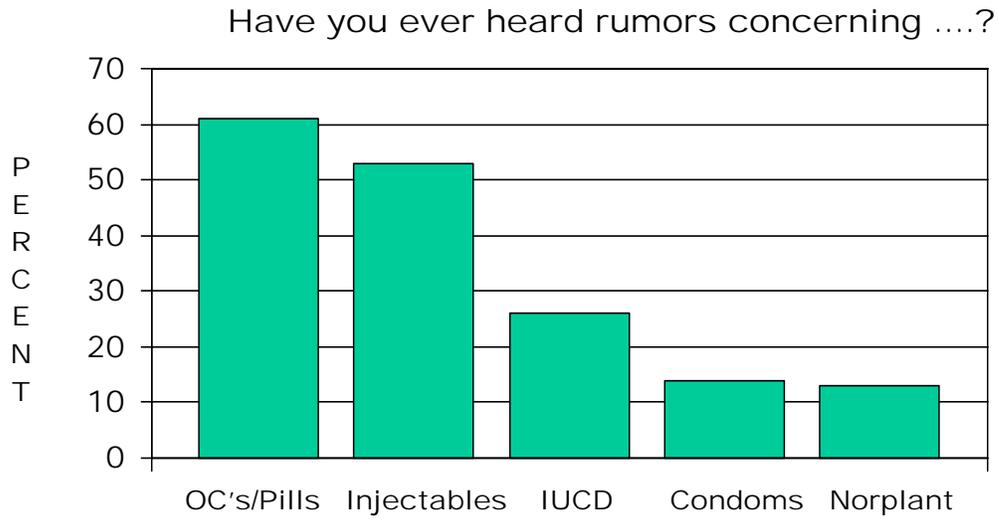


Figure 6: Rumors about pills
(n=95)

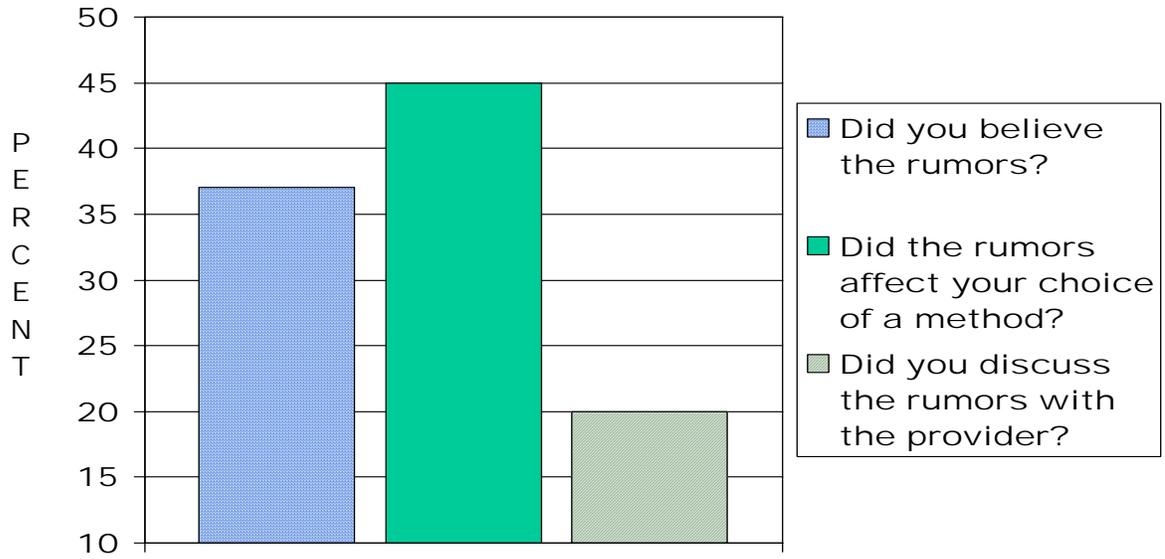


Figure 7: Rumors about injectables
(n=82)

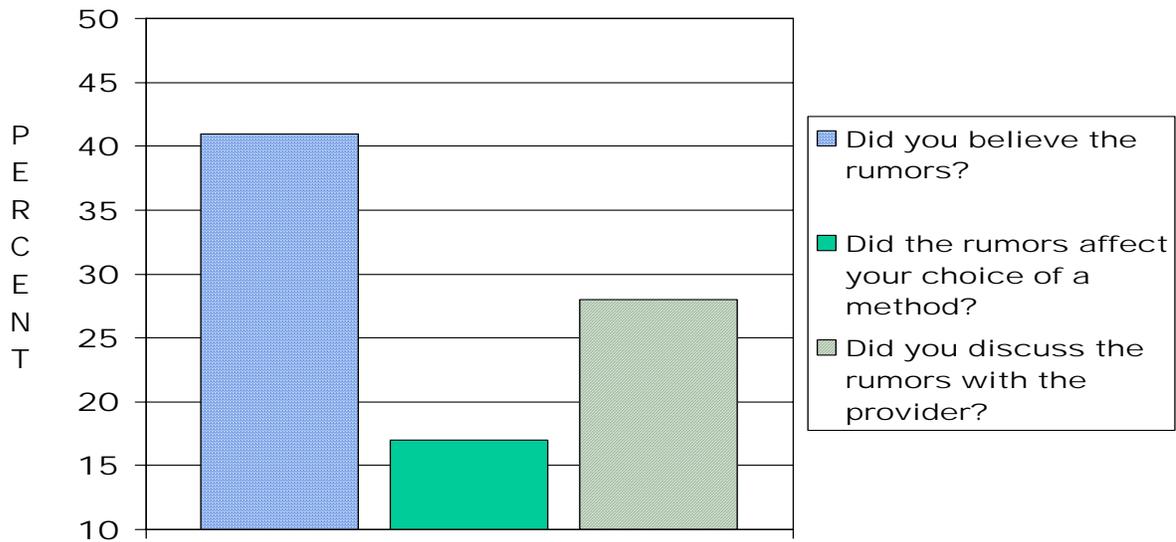
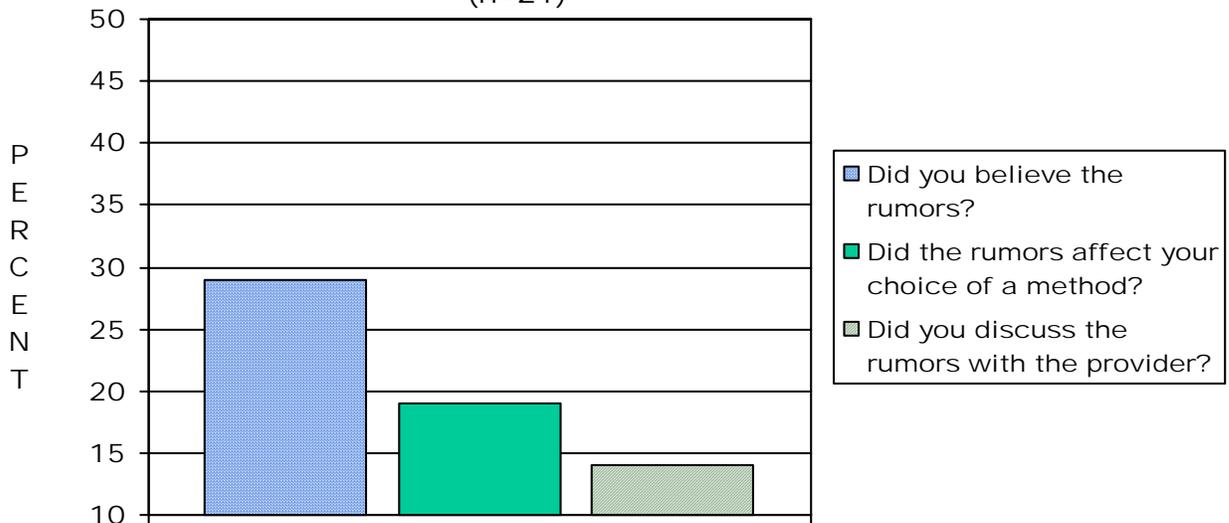


Figure 8: Rumors about IUCDs
(n=21)



Most clients (95%) reported that they are using the method that they want to use. Only seven said they were not and four of them said they wanted to be using injectables and two said Norplant. However, not receiving the method of choice appears to be a temporary measure since four said they are waiting until their next menstrual period so they can get the method they want.

Access to Family Planning Services and Methods

In terms of travel time and costs to go to the place where they get their contraceptive method, access for the client respondents was reasonably good (Table 5). The median time to travel to the clinic is 20 minutes and the median cost is 0 birr. Two-thirds believe their cost is reasonable.

Most clients (82%) are receiving their methods free of charge. For those who do pay, the average cost is 2.5 birr. Only six clients think the cost of their method is expensive. Three clients say there is another method they would like to try but it is too expensive; two said they would like to try Norplant and one would like to try injectables.

Fifteen percent reported that they have had trouble obtaining contraceptive supplies for their current method; of those, most had trouble obtaining injectables. Only nine clients had trouble obtaining supplies for methods they had used in the past; four each had trouble obtaining pills and injectables and one had trouble obtaining the IUCD.

Perceptions and Attitudes towards the IUCD

Over half of the clients (51%) reported they have ever heard of the IUCD (Table 6). Those who had heard of it were asked a series of questions about the IUCD. When asked what good things they had heard about the IUCD, more than half (55%) did not have anything good to say. These clients replied that they did not know anything good or had heard nothing good. About one-fourth said they had heard that it prevents pregnancy for a long time. When asked about what bad things they had heard, more than half (54%) said they did not know. The “bad” thing cited the most was that it does not go with heavy work, reported by 13%. Other bad things noted were that it will be lost in the women’s uterus, it causes ectopic pregnancy and it is bad to insert in the sex organ.

Few women had seen written information or heard about the IUCD on the radio. Similarly, only 16% had heard friends or relatives talk about the IUCD. Of the 13 clients who had heard talk about the IUCD, eight felt their family member or friend thought the IUCD was a good method and five did not.

Of those who had heard of the IUCD, more than one-fourth (28%) knew someone who was using or who had used the IUCD. Most of these clients felt that the person they knew was satisfied with the method.

Only nine women said they had considered using an IUCD, with four saying they considered it because it prevents pregnancy for a long time. Of the 58 women who said they would not consider it, the main reason was because they did not know enough about it followed by they do not think it is comfortable.

2. Provider Interviews

Provider Profile

As with the clients, the providers were not evenly distributed across regions and more than half were from either Amhara or Oromiya (Table7). The fewest number interviewed were from Addis. The majority of the providers interviewed were female and between

20-29 years old with an average age of 29.6 years. On average, they had worked as a health care provider for 9.4 years. None of the providers interviewed were physicians; 81% were nurses and the rest were health assistants or junior midwives. Family planning was the primary responsibility of 38% of providers followed by no definite responsibility (22%) and antenatal care (16%).

Of the 25 female providers interviewed, 12 said they would consider using the IUCD in the future. Only three had ever used one in the past. Over half were not currently using any method. Four were using injectables, two using IUCDs, and one each were using pills, implants, the calendar method or was currently pregnant.

IUCD training and supplies

Having adequately trained personnel and sufficient supplies can affect the provision of IUCD services. Half of the providers interviewed reported that they never received training on IUCD insertion and removal or on IUCD counseling (Table 8). For those who did receive training, the last time trained varied from within the last year to more than five years ago. Nearly all the training that was received came from an NGO.

Most providers (59%) reported that their clinics have never run out of IUCDs and only one ran out within the past year. Similarly, most had never run out of other supplies necessary for IUCD insertion e.g. sterile surgical gloves or cotton/wool. However, 10 percent or more ran out of these supplies within the past 12 months. When asked if there are other supplies necessary for IUCD insertions that were missing from the clinic on the day of the assessment, 24% said yes. The item missing most often was the bedside light and two providers said they were missing complete IUCD kits. Other items that one provider said were missing included forceps, iodine and gloves.

Experience with IUCD counseling and insertions

When counseling women about contraceptive methods available at their clinics, about two-thirds of the providers reported that they counsel about the IUCD either all or most of the time (Table 9). Only six percent said they either never or almost never counsel about the IUCD.

About half indicate that there are categories of women who they do not encourage to use the IUCD. Of those who do discourage certain women, nine say they discourage women with multiple sex partners. Women with a uterine infection or a sexually transmitted infection (STI)/Human Immunodeficiency Virus (HIV) would be discouraged by four providers each and one provider would discourage those with irregular menstrual periods.

Most (62%) of the providers had not inserted any IUCDs in the period of September through November 2004. About one-fourth inserted either one or two IUCDs and the rest inserted five or more. About half (49%) of the providers thought that IUCD use at their clinic had stayed the same over the past year while 22% felt use had increased and 11% felt use had decreased. On average, 41% reported it took them 30 minutes or less to insert an IUCD. Five percent reported it took them between 30 minutes and an hour, while one provider (3%) reported it took two hours.

IUCD Knowledge

Out of nine questions testing provider knowledge about the IUCD, on average they answered 4.1 correctly with a range of just one correct response to a maximum of six (Table 10). There was little difference in overall knowledge scores for those who reported they had been trained on IUCD insertions compared to those who had not been trained. Knowledge was particularly weak on the following questions: if a woman needs to be menstruating at time of insertion; if tarnished IUCDs are usable; if IUCDs are as effective as surgical sterilization over ten years; that the IUCD is effective for up to 12 years; and if the IUCD is a good contraceptive method for a woman who is HIV positive.

IUCD attitudes

Providers were asked a series of questions regarding their attitudes toward the IUCD as a method and also toward their training on the IUCD (Table 11). Out of nine statements assessing their attitude toward the IUCD as a method, on average, providers showed positive attitudes on 6.2 statements, with a range of two to nine. In this case, providers trained in IUCD insertions displayed more positive attitudes with an average score of 6.8, compared to those who were not trained who had an average score of 5.6. The least positive attitudes were displayed on statements about whether the IUCD is appropriate for women who do not have children and if the best candidates are women who cannot use hormonal methods.

Regarding attitudes toward their training and performing IUCD insertions and removals, on average, providers showed positive attitudes on 5.2 out of 11 statements, with a range of 0-11 (Table 12). Not surprisingly, there was a large difference in the scores of those who had been trained on IUCD insertions and those who were not. Those who were trained had an average of positive attitudes on 8.1 statements while those who were not trained had an average of 2.4. The statements showed that many providers did not feel comfortable with various aspects of IUCD provision including counseling, knowing contraindications, insertions and removals.

3. Facility Checklist

Family Planning and HIV Service Provision

Table 13 shows the median number of family planning clients in the three months prior to the health care facility assessment. The service statistics show that by far, the most clients are coming for injectables, followed by condoms and pills. There were very few IUCD insertions during this time period. In terms of family planning services provided, most clinics have provided injectables, condoms, pills, and Norplant insertions and removals during this time period. Only eight clinics reported performing IUCD insertions and removals. Even fewer reported performing either male or female sterilization services. Most clinics have also performed services to diagnose and treat STIs, and voluntary counseling and testing (VCT) of HIV. None of the clinics have a special time or day of the week for providing information and counseling on the IUCD.

Most of the facilities receive family planning or reproductive health referrals to their facilities at least sometimes (Table 14). Referrals often come from CBRH agents/ peer service providers and to a lesser extent from health posts or health clinics. The most

common reason for a referral is to switch to long-term or permanent methods. Six of the clinics reported that they sometimes refer their family planning clients to other facilities, most often a non-governmental organization (NGO) clinic or hospital. The most common reason to refer someone is for vasectomy.

Facilities have a variety of family planning/reproductive health IEC and counseling materials available on site (Table 15). Nearly all facilities have a family planning counseling flip chart and more than half have family planning posters, penile models and HIV/AIDS booklets. Few have family planning pamphlets or STI posters. On average, these facilities possessed an average of 3.1 of the six IEC materials assessed though one facility had none of these items while one had all of them.

Facility staffing and resources

On average, clinics have 57.8 health staff, including 1.5 physicians, working in their facility with a range of between nine and 122 (Table 16). Of these staff, an average of 2.2 are trained in IUCD insertion and removal techniques. Only one clinic did not have any staff trained in IUCD insertion and removal.

Table 16 also shows basic resources available at the health facility on the day of the assessment. Many items were not available. Most clinics had electricity, a refrigerator/freezer, bed/couch, toilet/latrine, and functional indoor taps. But few clinics had a separate room for IUCD insertions and removal, a bedside light, a source of light, or a generator.

IUCD insertion and removal equipment

Most of the facilities have at least some of the basic materials necessary for IUCD insertions and removals (Table 17). The equipment missing by the most number of clinics included towels, plastic coverings, dry sterilizers, steam sterilizers and cotton drawer sheets. In terms of the IUCD insertion kit, most clinics had all the necessary equipment though a few clinics were missing gloves or disinfectant solutions. More clinics were missing equipment necessary for removals. Few clinics had retrievers, six were missing gloves and four lacked antiseptic solution.

4. Policy Review

A review of policies and guidelines on family planning shows a favorable policy environment for an initiative to promote IUCD use in Ethiopia. The National Policy on Population highlights the need to diversify the method mix and provide greater contraceptive choices for clients. Furthermore, the National Policy on Women advocates for the right of women to have access to basic health care facilities including information about and services for modern family planning methods. In addition, the Ethiopian constitution incorporates international human rights as well as the International Planned Parenthood Federation (IPPF) charter on sexual and reproductive rights.

Current policies and the constitution outline three fundamental rights, while not specific to the IUCD, allow for the provision of IUCD information and high quality service delivery. These rights are:

1. The right to family planning information and education
2. The right to health care and the highest possible quality of care
3. The right to the benefit of scientific progress, including the right to new reproductive health techniques that are safe, effective and acceptable.

While current policies are conducive to promotion of the IUCD, it is unclear if current IUCD service delivery guidelines are being effectively disseminated to health care providers. Older guidelines may not have the most up-to date information. For instance the Manual on Maternal and Child Health Care from 1995, says that the IUCD is effective for eight years and the 1998 Family Planning Clinic Based Service Delivery Standards of Practice Manual says 10 years. Both say that only women who have previously given birth are eligible for an IUCD. These are guidelines that are not up to current international best practices such as those set forth in the World Health Organization (WHO) Medical Eligibility Criteria for Contraceptive Use. Anecdotal evidence suggests that family planning providers are not aware of current guidelines. Furthermore, MOH guidelines are not as a rule used in the medical schools though a new teaching manual including family planning information will soon be published.

IV. DISCUSSION

This assessment points to a number of factors that may be contributing to the low use of the IUCD in Ethiopia. First, clients have very little knowledge about the method and many have never even heard of it. Second, provider knowledge about the IUCD is weak though attitudes among those trained are essentially positive. Finally, a lack of trained providers can affect the facilities abilities to provide the IUCD.

The client survey shows that knowledge about the IUCD is low and is far surpassed by knowledge of other methods, i.e. injectables, pills and Norplant. Even among those who have heard of the IUCD, many did not know much beyond that it was a method, and could not say anything about it, either good or bad. The results suggest the IUCD is not even talked about much and few have even heard rumors about it. In contrast, many have heard rumors about injectables and pills, though these rumors do not appear to have much impact on their selection. Interesting, when asked what attributes are important to them in a contraceptive method, the two most important ones -- few side effects and effective at preventing pregnancy-- are both features of the IUCD. Yet few of the client respondents said they would consider using an IUCD, mostly because they do not know enough about it.

Only half of the providers in this assessment had received training on the IUCD. Surprisingly, knowledge scores between the trained and non-trained groups were not much different, and both groups had low average scores. While two-thirds reported that they provide counseling all or most of the time on the IUCD, weak knowledge will impact their ability to provide good counseling to clients. It should also be noted that fewer clients said they received counseling on the IUCD than providers said they gave it. This may suggest that while providers are mentioning the IUCD they are not providing substantive information on it. In turn clients may not perceive that they are receiving counseling on the method.

Facilities need trained personnel and sufficient equipment in order to provide IUCDs. The average number of providers per facility trained in IUCD insertions and removals is low and could handicap a facility's ability to counsel on and provide it. While training did not have much impact on provider knowledge, it did impact their attitudes toward the IUCD, and those who were trained had more positive attitudes than those who were not trained. While equipment shortages do not appear to be a severe constraint at the moment, if demand were to grow, it may become a larger issue.

These three factors are interrelated and will all need to be addressed in order to increase IUCD use in Ethiopia. Increasing IUCD use rates should be of special importance in order to increase sustainability. The method distribution reflected in this assessment and the DHS shows a heavy reliance on injectables and to a lesser extent pills. Over the long term this is a very expensive method mix, one which would not be sustainable without substantial donor input. The United States Agency for International Development (USAID) 2004 commodity costs show that the IUCD costs \$1.65 whereas one year of

DMPA costs \$4.36 (\$1.09/vial) and pills costs approximately \$3.00 (\$0.75/3 pack).³ Therefore, while IUCDs may seem expensive up front, in fact they are very inexpensive in the long term. Given that many women in this study stated they planned to use injectables for four or more years, IUCDs may be a more viable alternative for programs.

V. Recommendations

The following are some of the recommendations that come from this assessment:

5. Promote the IUCD in the community. Clients should be motivated to initiate use and receiving information will be a first step. Satisfied IUCD users could be useful role models for other clients.
6. More providers must be trained at a minimum in basic facts about the IUCD so that they can provide counseling. Training should incorporate current international service delivery guidelines to update provider knowledge. This training may also increase positive attitudes about the IUCD among providers which will come through during client counseling. IUCD counseling should take place at all counseling sessions about methods. Refresher training will be needed periodically.
7. As costs allow, it will be helpful to increase the number of providers trained on insertions and removals. Meanwhile, referral networks can be strengthened. Careful monitoring should also take place of IUCD supplies so that if demand increases, facilities can take care to not run out of equipment needed to do insertions and removals.
8. Policies and service delivery guidelines should be reviewed and updated as needed to reflect current international knowledge and practices on the IUCD.

³ International Drug Price Indicator Guide, <http://erc.msh.org>

Appendix #1: Tables

Table 1. Client sociodemographic data

	Number (N=155)	Percent
Region		
Addis Ababa	21	14%
Amhara	60	39%
Oromiya	47	30%
SNNP	27	17%
Total		100%
Ethnicity		
Amhara	75	48%
Hadiya	8	5%
Oromo	41	26%
Guraghe	10	6%
Wolayta	6	4%
Kembata	8	5%
Other	7	5%
Total		99%
Religion		
Ethiopian Orthodox	81	52%
Protestant	30	19%
Muslim	39	25%
Other	5	3%
Total		99%
Age		
Average	28.0	
Range	15 – 45	
Marital Status		
Never married	11	7%
Currently married	138	89%
Divorced/widowed	6	4%
Total		100%
Ever attended school		
Yes	103	66%
Highest grade completed (of those ever attending school)		
	(N=103)	
0	7	7%
1 – 6	47	46%
7 or more	48	47%
No response	1	1%

Table 1. Sociodemographic data, continued

	Number (N=155)	Percent
Number of clients ever given birth	150	97%
Number of living children		
0 (Not given birth)	5	3%
1 – 3	95	61%
4 or more	54	35%
No response	1	1%
Total		100%
Number of living children (of those ever giving birth) (Average and Range)	3.2	1 – 10
Totals may not equal 100% due to rounding.		

Table 2. Client family planning counseling

Methods the client was told about when first went to clinic	Number (N=155)	Percent
Pills	130	84%
Condoms	73	47%
Foam Tablets	8	5%
IUCD	79	51%
Injectable	137	88%
Norplant	102	66%
Female Sterilization (Tubal ligation)	57	37%
Male Sterilization (Vasectomy)	25	16%
Don't Remember	2	1%
None	3	2%
Number of methods client was told about when first went to clinic (of the 8 listed above)		
Average	3.9	
Range	0 – 8	
Was given enough information to make a good decision about which method to choose	108	70%
The counseling received helped in decision which method to use	118	76%
Someone helped to make decision on which method to use	66	43%
Who helped you decide (of those who had someone help them) (more than one response per participant is possible)	(N=66)	
Husband/Partner	18	27%
Friend or Relative	8	12%
Health Professional	42	64%
CBRH	3	5%
Other	3	5%
Do you feel that women are free to choose their method or do providers and counselors tell them which to choose?	(N=155)	
Free to choose	92	59%
Providers/counselors tell them	47	30%
Don't Know	16	10%
Total		99%
Totals may not equal 100% due to rounding.		

Table 3. Client family planning method use

	Number (N=155)	Percent
How long have you used this method continuously (months)		
No response	1	1%
0 / Just received	28	18%
1 –12	70	45%
13 to 24 months	21	14%
25 to 36 months	11	7%
More than 36 months	24	15%
Total		100%
Average and Range (excluding those who have just received the method)	22.4	1 – 96
How much longer do you expect to use this method (months)		
Don't know	90	58%
Overall Average and Range for those who responded	44.6	1 – 120
Pills Average and Range	36.2	1 – 94
Injectables Average and Range	45.2	6 – 120

Table 4. Client method choice

	Number (N=155)	Percent
Reason for using family planning now		
Space births	93	60%
To limit births	54	35%
No intention to give birth	8	5%
Total		100%
Are you using the method you want to use		
Yes	148	95%
No	7	5%
Total		100%
What is your method of choice (of those who are not using their method of choice)		
	(N=7)	
Injectables	4	
Norplant	2	
Other	1	
Why are you not using your method of choice (of those who are not using their method of choice)		
Provider prescribed until next menstrual period	4	
No reason	1	
“Didn’t consult my husband”	1	
Breastfeeding	1	
Does your husband know you are using your current method		
	(N=155)	
Yes	140	90%
Does he approve of this method (of those with husbands are aware of the current method)		
	(N=140)	
Yes	137	98%
Are there any other methods he does not want you to use (of those with husbands are aware of the current method)		
Yes	12	9%
Which methods does your husband not want you to use (of those with husbands who have methods they do not want the client to use)		
	(N=12)	
Pills	3	
Condoms	4	
IUCD	5	
Injectables	3	
Norplant	5	
Female Sterilization (tubal ligation)	3	
Other	2	

\ **Table 4. Client method choice, continued**

	Number (N=155)	Percent
Most preferred FP method among friends and relatives		
Pills	16	10%
Condoms	8	5%
Injectables	101	65%
Norplant/Implants	5	3%
Female Sterilization	1	1%
Don't know	24	15%
Total		99%
Totals may not equal 100% due to rounding.		

Table 5. Client access to family planning services

How long does it take to get to where you get your contraceptive method (minutes)	Number (N=155)	Percent
Median	20	
Average	41.2	
How much did it cost to get here (in Birr)		
0	95	61%
1 – 9	48	31%
10 – 19	8	5%
20 or more	4	3%
Total		100%
Median	0	
Average	1.6	
Is cost to get here ... (of those who had to pay to get here)	(N=60)	
Expensive	20	33%
Reasonable	40	67%
Total		100%
Cost to get here, by those who indicated ...		
“It is expensive to get here”		
Median cost	2.0	
Average cost	4.9	
“It is reasonable to get here”		
Median cost	1.0	
Average cost	3.7	
Is the method you are using free or do you pay	(N=155)	
Free	129	83%
With Pay	26	17%
Total		100%
How much did you pay for your last supply	(N=26)	
1	7	27%
3	19	73%
Average	2.5	
Is the amount paid for your method ...		
Expensive	6	23%
Reasonable	20	77%

Table 5. Access, continued

	Number (N=155)	Percent
Is there another method you would like to try, but it is too expensive		
Yes	3	2%
What method is too expensive	(N=3)	
Injections	1	
Norplant	2	
Have you ever had trouble obtaining your contraceptive supply, for your current method	(N=155)	
Yes	24	15%
No	128	83%
Never tried to get supplies	3	2%
Total		100%
Method client had trouble obtaining	(N=24)	
Pills	3	
Injectables	20	
Norplant	1	
Have you ever had trouble obtaining your contraceptive supply, for any past methods	(N=155)	
Yes	9	6%
No	131	85%
Never tried to get supplies	15	10%
Total		101%
Which past method have you had trouble getting	(N=9)	
Pills	4	
IUCDs	1	
Injections	4	
Totals may not equal 100% due to rounding.		

Table 6. Client perceptions and attitudes towards the IUCD

Have you ever heard of the IUCD	Number (N=155)	Percent
Yes	79	51%
No	76	49%
Total		100%
The remaining questions are asked only of those who have ever heard of the IUCD (N=79)		
What good things have you heard about the IUCD	(N=79)	
Prevents pregnancy for long	19	24%
Causes no problem for users	5	6%
Can be removed at any time	2	3%
No serious side effects	4	5%
Heard nothing good about it	24	30%
Heard only about its existence	3	4%
Don't know	20	25%
What bad things have you heard about the IUCD		
Will be lost in women's uterus	5	6%
Causes ectopic pregnancy	4	5%
Bad to insert in sex organ	4	5%
Doesn't go with heavy work	10	13%
Others	6	8%
Don't know	43	54%
Have you ever seen written information about the IUCD or heard about it on the radio		
Saw written information	2	3%
Heard about it on the radio	4	5%
Both	2	3%
Neither	60	76%
No response	11	14%
Total		101%
Have you heard friends/relatives talk about the IUCD		
Yes	13	16%
No	55	70%
No response	11	14%
Total		100%

Table 6. Perceptions and Attitudes towards the IUCD, continued

Regarding the talk from your family and friends, do you get the impression they think IUCDs are a good method to use	Number (N=13)	Percent
Yes	8	
No	5	
Do you know anyone who uses or has used the IUCD		
Yes	22	28%
No	46	58%
No response	11	14%
Total		100%
Of those using the IUCD, are they satisfied with this method	(N=22)	
Yes	16	73%
Would you ever consider using the IUCD	(N=79)	
Yes	9	11%
No	58	73%
No response	12	15%
Total		99%
Why would you consider using the IUCD (among those indicating they would consider using the IUCD)	(N=9)	
Prevents pregnancy for long	4	
Provider informed me as IUCD is good	2	
Other	4	
Why would you not consider using the IUCD (among those indicating they would not consider using the IUCD)	(N=58)	
Not interested in using it	8	14%
Don't know well about it	15	26%
Use other more convenient method	5	9%
Don't think it is comfortable	12	21%
Doesn't go with heavy work	7	12%
Shame to show own sex organ	4	7%
Causes abortion	1	2%
Afraid of becoming infertile	3	5%
Others, not specified	4	7%
Totals may not equal 100% due to rounding.		

Table 7. Provider profile

	Number (N=37)	Percent
Region		
Addis Ababa	4	11%
Amhara	14	38%
Oromiya	11	30%
SNNP	8	22%
Total		101%
Sex		
Female	26	70%
Male	11	30%
Total		100%
Age		
20 – 29	22	59%
30 – 39	11	30%
40 – 49	3	8%
50 – 59	1	3%
Total		100%
Average	29.6	
Total number years of service		
0 – 9	22	59%
10 – 19	10	27%
20 and more	5	14%
Total		100%
Average	9.4	
Number years of service at this clinic		
0 – 9	28	76%
10 – 19	7	19%
20 and more	2	5%
Total		100%
Average	6.1	

Table 7. Provider profile, continued

	Number (N=37)	Percent
What is your professional grade		
Nurse	30	81%
Health Assistant	5	14%
Junior Midwifery	2	5%
Total		100%
Current primary responsibility at this clinic		
Family Planning	14	38%
Antenatal care	6	16%
Labor and Delivery care	3	8%
HIV/AIDS	1	3%
Child health	2	5%
EPI	3	8%
No definite responsibility	8	22%
Total		100%
The remaining questions are asked only of female participants		
Would you consider using the IUCD in the future		
	(N=26)	
Yes	12	46%
Have you yourself ever used the IUCD		
Yes	3	12%
What method are you using now		
Injectables	4	15%
IUCD	2	8%
Pill	1	4%
Norplant/Implant	1	4%
Calendar method	1	4%
Currently pregnant	1	4%
No Method	14	54%
No response	2	8%
Total		101%
Totals may not equal 100% due to rounding.		

Table 8. Provider IUCD training and supplies at site

When was the last time you received training about IUCD insertion and removal?	Number (N=37)	Percent
Within the last 12 months	6	16%
1-5 years ago	6	16%
More than 5 years ago	6	16%
Never	19	51%
Total		99%
Who provided that training? (of those who ever had a training)		
NGO	18	
When was the last time you received counseling training that covered IUCD counseling?		
Within the last 12 months	6	16%
1-5 years ago	6	16%
More than 5 years ago	7	19%
Never	18	49%
Total		100%
Who provided that training? (of those who ever had a training)		
NGO	18	
Pre-service	1	
When is the last time your clinic ran out of IUCDs		
Within the last 12 months	1	3%
More than one year ago	8	22%
Never	22	59%
Don't know	6	16%
Total		100%
When is the last time your clinic ran out of Sterile Surgical Gloves		
Within the last 12 months	5	14%
More than one year ago	7	19%
Never	20	54%
Don't know	5	14%
Total		101%

Table 8. IUCD training and supplies at site, continued

When is the last time your clinic ran out of Cotton/Wool	Number (N=37)	Percent
Within the last 12 months	4	11%
More than one year ago	4	11%
Never	24	65%
Don't know	5	14%
Total		101%
Are there any other supplies or equipment necessary for inserting IUCDs that are missing from your clinic today?		
Yes	9	24%
No	17	46%
Don't Know	11	30%
Total		100%
What are they? (of those with any missing items)		
	(N=9)	
Forceps	1	
Iodine	1	
Bedside Light	4	
Gloves	1	
Complete IUCD kit	2	
Totals may not equal 100% due to rounding.		

Table 9. Provider IUCD counseling and insertions

When counseling women about the contraceptive methods available at your clinic, how often do you tell them about the IUCD?	Number (N=37)	Percent
All the time	17	46%
Most of the time	8	22%
Some of the time	10	27%
Almost never	1	3%
Never	1	3%
Total		101%
Are there categories of women you do not encourage to use the IUCD?		
Yes	19	51%
No	18	49%
Total		100%
What are those categories (of those who indicated there are categories of women they do not encourage to use the IUCD)		(N=19)
With Multiple Sex partners	9	
Eroded uterus/infection of urethra	4	
With STI / HIV	4	
Irregular menstrual period	1	
No response	1	
How many IUCDs have you inserted in the last 3 months?		
0	23	62%
1 – 4	9	24%
5 or more	5	14%
Total		100%
Would you say that IUCD use in this clinic has increased, decreased, or stayed the same over the past year?		
Increased	8	22%
Decreased	4	11%
Stayed the same	18	49%
Don't know	7	19%
Total		101%
On average, how long does it take you to insert an IUCD, including the time you spend counseling the client about the IUCD?		
30 minutes or less	15	41%
31 minutes – 120 minutes	3	8%
Don't Know/NA	19	51%
Total		100%
Totals may not equal 100% due to rounding.		

Table 10. Percent of providers with correct answers to IUCD knowledge questions

A woman must be menstruating at the time of IUCD insertion.	Number (N=37)	Percent
False	11	30%
A new IUCD user only needs to come back to the clinic once in the first year, unless there are complications with the IUCD.		
True	26	70%
A tarnished IUCD is no longer usable.		
False	3	8%
IUCDs cause the majority of the cases of pelvic inflammatory disease (PID) in Ethiopia.		
False	29	78%
Over a ten-year period, the IUCD is as effective as sterilization in preventing pregnancy.		
True	4	11%
The IUCD is less effective at preventing pregnancy than oral contraceptives.		
False	28	76%
A copper IUCD is effective for up to 12 years		
True	5	14%
The IUCD is different because it causes abortions		
False	33	89%
An IUCD is not a good contraceptive method for a woman who is HIV positive.		
False	11	30%
Number of correct responses (out of 9 total)	Average	Range
Overall	4.1	1 – 6
Trained staff	4.2	2 – 6
Untrained staff	3.9	1 – 6

Table 11. Percent of providers with positive attitudes towards the IUCD

I would recommend the IUCD to a friend or family member.	Number (N=37)	Percent
Agree	35	95%
IUCDs can lead to infertility		
Disagree	35	95%
The IUCD is an appropriate method for those who are not married		
Disagree	24	65%
A woman should use the IUCD only when she does not want more children.		
Disagree	27	73%
The best candidates for IUCD use are women who cannot use hormonal methods		
Disagree	14	38%
Given the advantages of the IUCD, it should be used by more Ethiopian women.		
Agree	31	84%
Many people are allergic to the copper IUCDs		
Disagree	27	73%
The IUCD is an appropriate contraceptive method for women who do not have children.		
Agree	12	32%
The cost and trouble of inserting an IUCD are worth it for the client in the long-term.		
Agree	35	95%
Number of positive attitudes about IUCDs		
	Average	Range
Overall	6.2	2 – 9
Trained staff	6.8	4 – 9
Untrained staff	5.6	2 – 9

Table 12. Percent of providers with positive attitudes towards IUCD training and insertions

	Number (N=37)	Percent
When inserting the IUCD, I worry about infecting myself with a sexually transmitted infection/HIV/AIDS.		
Disagree	21	57%
There are too many issues to consider when deciding if a woman can use an IUCD.		
Disagree	3	8%
I feel that I have been adequately trained on <i>counseling</i> women about the IUCD.		
Agree	18	49%
I feel comfortable explaining how the IUCD works		
Agree	27	73%
I feel that I have been adequately trained on contraindications to the IUCD		
Agree	16	43%
I feel that I have been adequately trained on how to insert an IUCD		
Agree	15	41%
I feel that I have been adequately trained on how to remove an IUCD		
Agree	17	46%
There are many days when I am too busy to insert an IUCD		
Disagree	25	68%
It is very difficult to convince clients that rumors about the IUCD are not true.		
Disagree	17	46%
I feel comfortable that I can insert an IUCD safely and effectively		
Agree	16	43%
I feel comfortable that I can remove an IUCD safely and effectively		
Agree	16	43%
Number of positive attitudes about their training	Average	Range
Overall	5.2	0 – 11
Trained staff	8.1	2 – 11
Untrained staff	2.4	0 – 7

Table 13: Average number of family planning and HIV service clients for all facilities in the past 3 months

Number of FP clients during the past 3 months, by type	Average (N=15)	Median	Range
Pill- new user	125.7	101	13 – 409
Pill-continuing user	82.3	45	1 – 305
Condoms	259.9	36	0 – 3,000
Injectables	770.0	695	307 – 2,184
IUCD	3.5	1	0 – 18
Norplant	29.6	17	0 – 199
Tubal Ligation	2.3	0	0 – 11
Vasectomy	0.3	0	0 – 3
Number of clinics that provided services in past 3 months			Number (N=15)
Pill provision			14
Condom provision			15
Injectable provision			15
IUCD Insertion			8
IUCD Removal			8
Norplant Insertion			13
Norplant removal			12
Male Sterilization			4
Female Sterilization			5
Syndromic Diagnosis of STIs			12
Laboratory Diagnosis of STIs			11
Treatment of STIs			13
VCT on HIV/AIDS			13
Does this facility have a weekly schedule (or special day/time) for providing IED and Counseling materials			
No			15
Total			15

Table 14: Referrals to and from facilities

Does this facility receive Family planning/reproductive health (FP/RH) referrals from other facilities	Number (N=15)
Yes, often	5
Yes, sometimes	8
Rarely/Never	2
Total	15
Types of FP/RH facilities most often send referrals here*	
CBRH agents/Peer Service providers	11
Health Posts	6
Health Center/Clinic	5
Hospital	3
The most common reasons for FP/RH referrals being sent here*	
Method complication	4
Switch to long-term/permanent method	13
Termination of pregnancy/Abortion	4
Need for alternative short-term/temporary method	5
IUCD Insertion/Removal	1
Vasectomy	1
Does this facility refer FP/RH clients to other facilities	
Yes, often	0
Yes, sometimes	6
Rarely/Never	9
Total	15
Which types of facilities are FP/RH clients most often referred	
Zonal Hospital	3
NGO clinic/hospital	8
Regional hospital	3
Other	1
Total	15
Most common reason for FP/RH referrals*	
IUCD	2
Infertility case	2
Impotency and Frigidity	2
Vasectomy	6
Tubal Ligation	3
Cervical Cancer	1
Shortage of Depo	1
Abnormal Uterine bleeding	1
Others	4
*More than one response possible.	

Table 15: IEC counseling materials available at facilities

IEC and Counseling materials available at site	Number (N=15)	Average (Range)
FP Counseling Flip chart	14	
FP pamphlets/Leaflets/brochures	5	
FP Poster	8	
HIV/AIDS booklets	8	
Penile Model	8	
STI Poster	3	
Average: <i>On average the facilities have 3.1 of the 6 main items</i>		3.1 0 – 6
Frequency distribution		
0	1	
1	2	
2	3	
3	2	
4	4	
5	2	
6	1	
Total	15	

Table 16: Facility staff and resources.

Number of health staff working in this facility	Average (N=15)	Range
Total	57.8	9 – 122
Number staff trained in IUCD insertion and removal (average)* ¹	2.2	0 – 7
Number in following categories		
Medical Doctor (MD)	1.5	0 – 10
Health Officer	0.2	0 – 1
BSc Nurse	0.2	0 – 2
Nurse / /Midwife	2.3	0 – 7
Clinical Public Health Nurse	1.9	0 – 14
Junior Nurse	0.7	0 – 3
Health Assistant	1.7	0 – 5
Laboratory technician	1.5	0 – 6
Other	0.3	0 – 4

*¹ – One (1) Facility indicated they did not have any staff trained in IUCD insertion and removal

Table 16: Facility staff and resources, continued

Resources available	Number (N=15)
Separate room for IUCD insertion and removal	4
Bed/Couch	12
Electricity (from outside power plant)	14
Generator	3
Source of light	3
Functional indoor taps	10
Functional outdoor taps	9
Regular, adequate supply of well water	7
Toilet or Latrine	12
Refrigerator or Freezer	13
Bedside Light	4
Ambulance	5
Vehicles (other than an Ambulance)	9

Table 17. IUCD insertion and removal equipment at facilities

	Number (N=15)
Equipment	
Examination bed/couch	14
Plastic Covering / Plastic draw sheet	10
Cotton draw sheet	8
Dry Sterilizer	10
Steam Sterilizer	10
Pick up forceps with holders	14
Towel	11
Cotton wool	13
IUCD	14

Table 17. IUCD insertion and removal equipment, continued

IUCD Insertion Kit	Number (N=15)	Average (Range)
Speculum	15	6.5 (1 – 24)
Uterine Tenaculum	15	2.9 (1 – 8)
Uterine Sound	15	3.1 (1 – 8)
Cutting Scissors	15	3.3 (1 – 8)
Kidney Dish	15	3.9 (1 – 11)
Gloves	12	52.7 (0 – 200)
Disinfectant Solutions (e.g. Iodine, soap, etc.)	13	4.0 (0 – 50)
IUCD Removal Kit		
Kidney dish	15	2.9 (0 – 10)
Sponge Forceps	15	3.1 (1 – 8)
Straight Forceps	13	1.8 (0 – 6)
Speculum	15	5.3 (0 – 24)
Retriever	4	0.3 (0 – 2)
Gloves	9	38.0 (0 – 200)
Antiseptic Solutions	11	3.7 (0 – 50)

Appendix #2: Policy Documents Reviewed

1. Andargachew Tesfaye. Twenty five years of family planning in Ethiopia- past, present and the future. 1991, in FGAE, Twenty five years of family planning services in Ethiopia, pages 3-20.
2. Daniel Haile. Legal aspects of family planning in Ethiopia. 1991, in FGAE, Twenty five years of family planning services in Ethiopia, pages 59-73.
3. MOH. Manual on maternal and child health care. 1995.
4. MOH. Guidelines for family planning services in Ethiopia. 1996.
5. MOH. Family planning clinic based service delivery standards of practice manual. 1998.
6. MOH/FHD. Technical guidelines in maternal and newborn care. 1998.
7. Office of Prime Minister, Transitional Government of Ethiopia (TGoE). National policy on Ethiopian women. 1993.
8. Office of the Prime Minister, TGoE. National population policy of Ethiopia. 1993.
9. TGoE. Health sector strategy. 1995.