

NIGERIA

**THE FAMILY PLANNING
SITUATION ANALYSIS STUDY**

Primary Health Care Unit
Federal Ministry of Health
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I. INTRODUCTION

1. The Nigeria family planning programme

Nigeria is by far the most populous country in Africa, with a total population of 88.5 million in 1991. In terms of population size and dynamics, therefore, it dominates the continent. A population growth rate of 2.7 and a total fertility rate of 6.3 indicate that these absolute numbers will continue to increase at a very substantial rate¹. An infant mortality rate of 104/1,000 and maternal mortality rate of 800/100,000 further illustrate the seriousness of the demographic and health issues facing the Nigerian Government².

Recognizing the consequences and implications of this situation at the family and societal levels, and on the GDP, agricultural development, land and energy resources, education, employment and health, the Government of Nigeria approved a "National Policy on Population for Development, Unity, Progress and Self-reliance" on February 4th, 1988. The goals of this policy are:

- "to improve the standards of living and the quality of life of the people of this nation;
- to promote their health and welfare, especially through preventing premature death and illness among high risk groups of mothers and children;
- to achieve lower population growth rates, through reduction of birth rates by voluntary fertility regulation methods that are compatible with the attainment of economic and social goals of the nation;
- to achieve a more even distribution of population between urban and rural areas."

To achieve these policy goals, a number of strategies are outlined in the policy statement, of which one of the most important is seen to be the provision of family planning services that are easily affordable, safe and culturally acceptable.

The provision of family planning services in Nigeria has only recently received attention from the Government. The Planned Parenthood Federation of Nigeria (PPFN) and a few university teaching hospitals took the lead in the 1960's and 1970's by educating certain sectors of the public, promoting modern family planning methods and meeting the limited demand that existed for contraceptives. Since 1983, however, USAID, UNFPA, The World Bank and other donor agencies have been increasing their technical and financial assistance to the Government for family planning through training, equipping health facilities, supplying and distributing contraceptive commodities, and policy development.

¹ Federal Office of Statistics, Institute for Resource Development/Macro Systems, Inc Nigeria Demographic and Health Survey 1990, April 1992.

² The State of the World's Children: 1990 UNICEF and Oxford University Press.

The major outcomes of this intensification of donor assistance have been the launching of the National Population Policy and the establishment of a five-year \$100 million Family Health Services Project (FHS), implemented jointly by the Federal Ministry of Health (FMOH) and USAID, to strengthen the provision of family planning services throughout the country. The FHS Project focuses on increasing the acceptability and availability of integrated family planning services throughout Nigeria in both the private and public sectors. The implementation of this project, along with a number of other population and family planning activities, demonstrates clearly the Government's commitment to achieving the goals of the Population Policy and to establishing a dynamic family planning programme.

Clearly, the national family planning programme in Nigeria is in its infancy and faces formidable hurdles if it is to achieve the targets for the year 2000 set in the National Population Policy. These include:

- extending coverage of family planning services to 50% of women of childbearing age;
- reducing the total fertility rate to 4 and population growth rate to 2.5;
- making available suitable family life education and family planning information and services to all adolescents.

Some indication of the scale of effort needed to reach these targets is that the recently completed national Demographic and Health Survey reported that only 44% of women interviewed knew of at least one modern method of family planning and only 33% knew where to get a method. Furthermore, only 9% of women have ever used and 3.5% are currently using a modern method.³

Given these parameters, the way in which the family planning programme develops is crucial to the achievement of the Population Policy's goals. To function effectively and efficiently, it is essential that the programme structures and operating procedures evolve in the most appropriate manner. A problem facing all newly developing programs is the need to learn rapidly how their structures are functioning, where the obstacles to improvement are, and what interventions are suitable. A start has been made in identifying these obstacles at the State level⁴, but little has yet been done at the level of individual Service Delivery Points (SDPs).

³ *op. cit.* Nigeria Demographic and Health Survey, 1992.

⁴ Fact Finding Missions undertaken by FHS have visited clinics and interviewed staff but have not examined the quality of care provided to clients.

2. The Situation Analysis approach

One approach to undertaking this rapid learning process at the SDP level is to use what has been termed a "situation analysis."⁵ This approach was developed by the Population Council's Africa Operations Research and Technical Assistance Project with assistance from staff of the Council's Ebert Program and first used in Kenya in 1989⁶. This initial study attracted substantial interest in Africa and additional studies have been undertaken in Burkina Faso, Zaire, Zimbabwe, Senegal, Tanzania, and Côte d'Ivoire.

Situation analysis studies are systematic examinations of the strengths and weakness of family planning programs focusing on all major subsystems and on the quality of care provided to clients. The first objective is to **describe the availability, functioning, and quality** of health and family planning activities in a representative sample of SDPs in a country. The major users of the findings from Situation Analysis studies are policy makers, administrators, and providers of services. Typically, the information is used to:

- diagnose supply side strengths and weaknesses;
- describe and assess the quality of services provided and received;
- develop policy recommendations for program guidance and possible redirection;
- identify areas for operations research field experiments;
- make necessary improvements in the range, type and quality of services provided;
- evaluate previous technical assistance inputs;
- establish baseline measures for planning and evaluating future technical assistance;

Using both observation and interviewing techniques, a situation analysis study employs a sample survey approach to select a representative number of family planning Service Delivery Points (SDPs) for examination. At each SDP, information is collected on a few key **indicators** of family planning subsystems, quality of care and SDP performance. The indicators help to provide managers and administrators with answers to three basic questions:

- 1) Is each subsystem in place, that is, ready to provide services? The subsystems, derived from experience with the PRICOR thesaurus⁷, are:
 1. Logistics/supplies
 2. Facilities/equipment
 3. Staffing
 4. Training
 5. Supervision/management
 6. Information, Education and Communication (IEC)
 7. Record Keeping

⁵ Fisher, Andrew, *et al* Guidelines and Instruments for a Family Planning Situation Analysis Study, The Population Council, New York, 1992.

⁶ Miller, Robert A, *et al*. "The situation analysis study of the family planning program in Kenya", Studies in Family Planning, 22(3):131-43, 1991.

⁷ Center for Human Services. Primary Health Care Thesaurus: A List of Service and Support Indicators, Chevy Chase, MD. 1988.

- 2) If in place, is each subsystem functioning, that is, ready to provide quality services?
- 3) If each subsystem is functioning, are quality services actually being provided and received? This question can be answered in terms of the six component quality of care framework developed by Judith Bruce⁸ and revised by Kumar, Jain and Bruce⁹, namely:
 1. Choice of contraceptive methods
 2. Provider-client information exchange:
 - a. understanding clients needs
 - b. information to clients
 3. Provider competence:
 - a. qualifications
 - b. technical competence (procedures followed)
 4. Client/provider relations
 5. Mechanisms to encourage continuity
 6. Constellation of services

For example, with regard to the logistics subsystem in Nigeria, one can ask is a mechanism in place for ordering and delivering contraceptive supplies? Second, if the system is in place, does it function to provide a wide range of contraceptive supplies to the SDP on a regular basis? Finally, in relation to quality of care, do the staff at the SDP provide a full range of information necessary for clients to make an informed choice between the different methods available? Thus after describing activities undertaken at the SDPs, this report will review the availability and functioning of the program sub-systems, being some of the determinants of the quality of services offered, and then discuss the quality of services observed at the SDPs.

⁸ Bruce, Judith. "Fundamental elements of the quality of care: A simple framework" Studies in Family Planning, 21(2):61-91, 1990.

⁹ Kumar, S., A. Jain and J. Bruce. Assessing the Quality of Family Planning Services in Developing Countries, Programs Division Working Papers No. 2, The Population Council, New York, 1989.

II. STUDY METHODOLOGY

1. Objectives

A. Ultimate Objective:

To provide comprehensive information on the availability, functioning, and quality of family planning services in Nigeria so that needed improvements and expansion can be planned and implemented.

B. Immediate Objective:

Over a period of approximately eight months between December 1991 and July 1992, the Operations Research Unit, Obafemi Awolowo University, Ile-Ife will coordinate a comprehensive study to describe the quality of care provided to clients and the availability and functioning of 181 service delivery points (SDPs) in the public and private sectors.

2. Data collection

A number of different data collection instruments and sources were needed in order to obtain the information required. The data collection instruments used, which had already been developed by Population Council staff in other Situation Analysis Studies, were customized for application in the Nigerian context during a planning workshop held at the Operations Research Unit, Obafemi Awolowo University in January 1992. The instruments used were:

- Inventory for Facilities Available and Services Provided at the Service Delivery Point
- Observation Guide for Interaction Between Consenting New Family Planning Client and Service Provider
- Exit Questionnaire for Family Planning Clients Attending the Service Delivery Point
- Interview Schedule for Staff Providing Family Planning At the Service Delivery Point
- Questionnaire for non-Family Planning Clients Attending the Service Delivery Point.

These instruments were used to collect data through observation and interview from the following sources:

- services statistics available at the SDP
- all staff responsible for providing family planning
- all new family planning clients
- a random sample of up to five continuing family planning clients
- a random sample of up to ten MCH clients

Field work was scheduled for 30 working days in March and April 1992. There were a total of six research teams for the national study who collected data from a sample of 30 SDPs, each team working in one state. Each research team consisted of an Associate Investigator acting as team leader, one social science field researcher with family planning programme experience, and one nurse/midwife with family planning training and program experience. These six teams were coordinated by the Principal Investigator, who is the Director of the OR Unit at Ile-Ife.

Immediately before the fieldwork began, a four-day training workshop was held at Ibadan for all six teams at which instruction in the approach as a whole and their particular responsibilities was given. Emphasis was placed on the importance of noting all relevant observations and impressions; the instruments listed above were only used as guidelines for the minimum items to be recorded. During the training, each team spent one day at an SDP to experience implementing the data collection instruments.

Experience with previous situation analysis studies had indicated that a one-day visit to an SDP provides sufficient time to collect data that can answer the research questions posed earlier; this approach maximizes the tradeoff between speed and validity inherent in any rapid appraisal method. Thus, typically at the beginning of the day, the nurse-midwife with clinical training would begin observing client and provider interactions. Later, this person would also help to complete the inventory of medical equipment. The social scientist usually would be responsible for client exit interviews and staff interviews. He/she also helped with collecting information on clinic records, reporting, and service statistics as well as counting contraceptive supplies available. The team leader, was specifically responsible for reviewing clinic records and undertaking the inventory, while being generally responsible for guiding the visit and for checking the responses and coding of the responses on the completed data collection instruments.

3. Sampling

The units of analysis for the situation analysis were the service delivery points (SDPs) within the national Primary Health Care programme that provide family planning services. Sample SDPs were selected randomly from the total number listed by the FMOH PHC Division in each of six states drawn from the four Health Zones of the country. The four 'geographical focus' States selected by the FHS Project were used; Anambra, Kano, Niger, and Osun. Lagos State was also sampled because of its pre-eminence in the amount of family planning activities undertaken there. The UK Overseas Development Administration (ODA) is considering focussing its aid in Benue State and thus this became the sixth State in the sample.

Nigeria is believed to have approximately 1400 public SDPs that provide family planning services¹⁰ in the country. Using the standard formula for proportions to calculate the appropriate sample size¹¹, a minimum of 171 SDPs needed to be sampled to be able to estimate proportions nationally. Dividing between the six states gives a minimum of 29 SDPs per state. The actual sample sizes per state are given below. The total of 181 family planning SDPs therefore represents a sample of over 10% of SDPs nationwide. The figures in parentheses in the table are the total number of SDPs by type in the state, indicating that for the six states in the study the proportion of the total number of SDPs sampled is 47%. Within each state the proportion studied varies considerably, with a range from 32% of all SDPs in Benue State to 94% in Anambra State.

A stratification by type of SDP was necessary because of the wide variety of SDPs that currently provide family planning. From an initial classification of twelve different types of SDP (drawn up during the planning meeting by a group of programme managers) a five-category classification was made for sampling purposes (see below). The managers suggested over-sampling for hospitals as it was felt that these were the primary sources of family planning for most clients; the Nigeria DHS supports this perception as Government hospitals were indeed the main source of supply (26% of current users interviewed).

SDP	States						Total	
	Lagos	Osun	Anambra	Benue Gov	Niger	Kano		
Hospital	7 (8)	8 (9)	5 (6)	8 (9)	8 (8)	7 (10)	10 (10)	53 (60)
Health centres	18 (67)	11 (22)	9 (10)	7 (30)	3 (38)	16 (48)	17 (19)	81 (234)
Clinics	2 (11)	8 (11)	14 (14)	2 (8)	1 (1)	7 (18)	2 (19)	36 (82)
PPFN	3 (3)	3 (3)	0	1 (1)		0	1 (1)	8 (8)
Private hospital	1 (1)	1 (1)	1 (1)	0		0	0	3 (3)
Total	31 (90)	31 (46)	29 (31)	30 (95)		30 (76)	30 (49)	181 (387)

¹⁰ Federal Ministry of Health, Department of Population Activities, Family Health Services: State Profiles, Lagos, 1990.

¹¹ For a full discussion of the sampling procedures used see ch. 8 in Fisher, A. *et al Handbook for Family Planning Operations Research Design*, The Population Council, New York, 1991.

All PPFN and private hospitals participating in the FHS Project in each state were included. For the categories of health centres and MCH clinics the sample sizes for each state were calculated by subtracting the number of hospitals and PPFN / private hospitals from the projected sample size of 30, and then distributing the remaining number between the two categories proportional to the number of each category in the state. For Benue State the SDPs of the missionary organization NKST were included because they have more SDPs than the Government, have been providing family planning for longer and are an integral part of the family planning service delivery system.

The study plan called for a number of interactions between family planning clients and providers to be observed at each SDP visited. In addition, a number of interviews were to be undertaken with family planning and MCH clients and with all service providers present on the day of the visit. The numbers of observations and interviews varied considerably by SDP and by State; the aggregate values for the national study are given in Table 1.

It is important to note that it was possible to observe interactions between family planning client and providers and to interview clients in only 94 SDPs, i.e. a little over half of the total visited (see Table 2). The primary reason for this was the lack of family planning clients on the day of the visit. If one assumes that the presence of clients is indicative of higher quality services, then where the assessment is based on observations of client/provider interactions and client interviews, it will be upwardly biased because the results are more likely to be drawn from the SDPs with more clients. Had the research teams kept visiting the other 87 SDPs until a family planning client

Table 1 Sub-sample sizes for the National Situation Analysis Study

Sampling Unit	Number
FP client/provider interactions observed	395
new clients	121
continuing clients	259
others	15
Client exit interviews	1443
new clients	131
continuing clients	259
MCH clients	1053
Staff interviewed	289
doctor	2
nurse-midwife	135
registered nurse	23
registered midwife	39
community midwife	5
community health officer	32
community health extension worker	33
nursing aid	12
other	8

Table 2 Distribution of observations and interviews within SDPs visited

Sampling unit	Number of SDPs	Percent of SDPs
Observations	94	52%
Family planning client interviews	94	52%
MCH client interviews (excludes PPFN)	149	86%
Staff interviews	158	87%

appeared, then they might have observed inferior services compared to the 94 SDPs where clients were present on the day of their visit. It should also be noted that not all family planning clients observed were interviewed and vice versa because in some SDPs, particularly the busier ones, to have done so would have disrupted the functioning of the SDP.

4. Data processing and analysis

Initial coding and checking of all data collection forms was undertaken in the field by the Associate Investigator. After two weeks of data collection, the Principal Investigator visited each team to collect the data and carry it to the OR Unit at Obafemi Awolowo University for entry on the computer. The Epi Info program¹² was used for data entry, editing and tabulation. Two clerks were used for data entry to speed the process. The Principal Investigator provided overall supervision of data entry and tabulation. Simple tabulations of data were produced using Epi Info and, where appropriate, graphic presentations made using the Harvard Graphics program.

These tabulations and graphics were reviewed and discussed during a data interpretation workshop held at Jos, attended by researchers and state / zonal level family planning managers; training and technical assistance was provided by The Population Council. The results were then used by each State team to:

1. describe the facilities available, services delivered, and commodities available at SDPs;
2. describe the availability and functioning of various family planning subsystems;
3. describe the quality of care provided and received at SDPs;
4. highlight the strengths and weaknesses of the programs;
5. develop a list of priority problems which may be influenced by administrative interventions;
6. develop specific plans for implementing administrative procedures at the State level.

5. Dissemination of study results

The Nigerian model for service delivery is relatively decentralized. In a decentralized system, it is essential to ensure that the study findings are used by state as well as national administrators. The effective dissemination and utilization of the findings can only be accomplished through the intimate involvement of the program managers in the planning, implementation, and analysis of the research data. More specifically, it was proposed to link the situation analysis study of Nigeria to a limited State and National planning process built around the planning, implementation, and utilization of the study results. This process includes four major elements:

¹² Dean, A. *et al.* Epi Info, Version 5: A Word Processing, Database and Statistics Programme for Epidemiology on Microcomputers. USD Inc., Stone Mountain, Georgia, 1990.

1. Involvement by the relevant program administrators and researchers in a three day **planning workshop** (held at Ile-Ife in January 1992) which stimulated participation in the process of adapting the standard situation analysis research protocols to the Nigerian context (but still maintain comparability of data in the different regions).
2. A four-day **data interpretation workshop** (held at Jos in May 1992) attended by the same participants as the planning workshop. Data was available at the State and national levels. At this meeting six state teams were formed to jointly review the data, develop presentations of selected major findings in easily understandable formats, and determine selected priority problems amenable to administrative intervention. Six state level reports have been prepared following this workshop. This report describes the findings and programmatic recommendations for the national level only and those interested in the State level results should consult the State reports.
3. A one-day **national dissemination seminar** (held at Lagos in July 1992) to present results to national-level policy makers and managers. The draft version of this report formed the basis of this seminar and the policy and programme recommendations that emerged from the seminar are included in Section IV of this report.
4. Three one-day **zonal dissemination seminars** (in locations to be determined in each zone) are being held in October 1992 to present the state level results to managers at the zonal, state and LGA levels. These presentations will be based on the state reports and the objective is to encourage those most directly concerned with service delivery to consider possible actions that could be taken to improve the functioning and quality of the service delivery system.

III. RESULTS

1. Activities at the SDPs

a) Family planning services

The data for this section were gathered from the service statistics available at each SDP visited. Of the 181 SDPs, only 152 (i.e. 84%) had complete service statistics that could be used and the poor quality of the service records was a major hindrance in collecting data for this study (see later). Figure 1 demonstrates clearly that SDPs are not providing services at equal levels of intensity; indeed, only 19% of the SDPs provide services to three quarters of all new clients.

The conclusion is that provision of services is highly concentrated in a small number of SDPs while the majority are offering very few services; indeed, 6% of the SDPs visited did not provide any methods at all during 1991. It should be noted that the relationship displayed in Figure 1 is not just attributable to the fact that larger facilities serve more clients. Examining this relationship within particular types of facilities indicates that the association still holds. For example, 20% of the 50 hospitals with useable service statistics serve 69% of the all the clients who visit hospitals, while the remaining 80% of the hospitals serve only 31% of the clients.

Figure 1 Percent of 152 SDPs providing FP services to 47,588 new clients in 1991

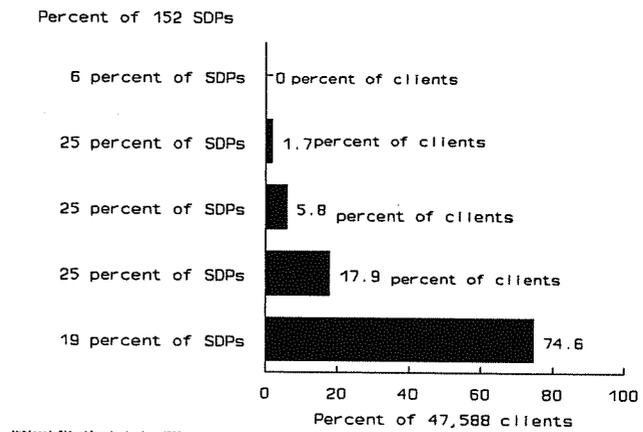


Table 3 Summary statistics for new and revisit FP clients and MCH clients for the last month with complete statistics in 1992 and for the entire year of 1991

	For last month		For year of 1991		
	new FP acceptors	FP revisits	new acceptors from 152 SDPs	revisits from 150 SDPs	MCH visits from 128 SDPs
Total	5,827	10,555	47,588	114,072	877,489
SDPs with no clients	3%	7%	6%	8%	5%
median	11	25	93	232	1996
maximum	396	807	6,403	9,174	76,402

Further confirmation of the differences in the level of family planning activities among SDPs is revealed in Table 3. The distribution of family planning clients shows that while the median number¹³ of new clients seen *during the last month* at an SDP is as low as eleven (that is, approximately one new client every two working days), the maximum number of new clients at one SDP is close to 400 (i.e. approximately 20 new clients per day); a similar disparity was observed for the revisit clients and for clients served over the previous year¹⁴. It is worth noting that the median number of new acceptors for the previous year represents only eight per month, implying a slight improvement over time. As will be seen later, some of the low level of provision may be due to the non-availability of contraceptive supplies, but also a serious problem are those SDPs where the staff claim not to provide family planning, even though their clinic is designated as a family planning SDP by the State level administration.

Appendix 1 gives a breakdown of the type of family planning services provided during the last month at those SDPs with complete statistics available. It appears that most clients receive the pill (28% of new acceptors), the condom (21%), the IUD (19%), or spermicides (18%); a further 10% received an injectable and 2% sterilization; it is worth noting that there were even two vasectomies recorded!

As shown in Table 3 and Appendix 1, most SDPs see many more revisits than new family planning clients; this proportion was also found during this study as 34% of family planning clients interviewed were new and 66% were continuing users. Foremost among those interviewed was the resupply of methods currently being used or for a follow-up for the method already adopted (50%), while 34% were new acceptors. It is noteworthy that 10% came because they had problems with methods they were using and 7% came to either stop, switch or seek information on family planning methods.

b) Accessibility of SDPs

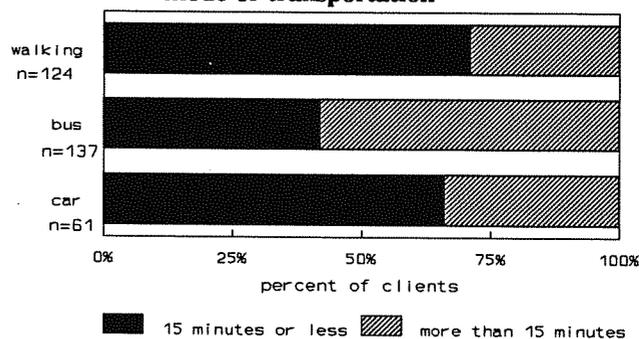
The accessibility of SDPs is an important determinant of whether or not a client is able to use family planning services. One way to assess whether clients have access to the SDPs was to ask for their mode of transportation to the clinic. The responses to this question revealed that 45% of the 1,430 family planning and MCH clients went to the SDP on foot. This might imply that SDPs were within easy access of the clients; however, another 42% of the clients reached the clinic either by a car or bus and 12% came by other means of transport.

¹³ The median is used rather than the mean because of the great range in family planning activities between the SDPs.

¹⁴ The number of SDPs refers to those with available service statistics. For the last month the number of SDPs with complete service statistics varied for each method and so the total given for the month is summed from all SDPs recording acceptors for each method. Because of missing data from many SDPs the figures represent an undercount.

The mean time spent travelling to the SDP is remarkably short, 24 minutes. Those walking to the SDP did not walk long distances; 71% spent 15 minutes or less and only 10% took more than half an hour. Those coming by bus (31 minutes) and car (24 minutes) took longer on average, possibly because they were more likely to be travelling to an SDP that was not the closest to their home (see Figure 2). The interpretation of this measure of accessibility is complicated by the fact that a substantial

Figure 2 Travel time by FP clients to the SDP, by mode of transportation

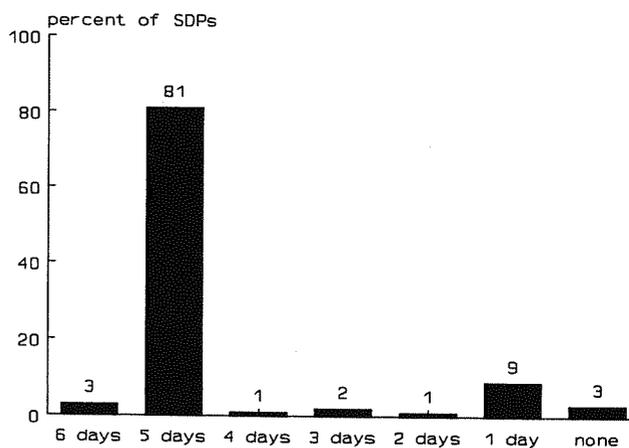


National Situation Analysis, 1992

proportion (41%) of family planning clients do not go to the nearest clinic to their home. When asked why, of the 161 women who said that they did not visit the nearest clinic, only three respondents explicitly gave anonymity as the reason. The majority said it was because of better services (63%) or a wider range of services (7%) being available at the clinic visited. Whether this means that family planning services were not available at the nearest clinic is not clear. Twenty-eight percent gave other reasons, including attendance at staff clinics which were not necessarily the closest SDP to where they live.

Another measure of accessibility is how frequently an SDP is open and whether it opens on time. From Figure 3, it is apparent that most of the SDPs visited provided family planning five days a week; less than 10% of SDPs offered services only once a week. Generally, therefore, family planning services in Nigeria would not seem to be restricted because of the number of the days family planning is offered. These data were collected through staff interviews and not through observation and thus it is not possible to verify whether services are actually as available as claimed by the staff.

Figure 3 Number of days per week FP services are offered at 177 SDPs



National Situation Analysis, 1992

SDPs that open punctually reduce the time clients spend at the SDP which undoubtedly encourages clients to return. The research teams arrived at 156 SDPs prior to the official opening time and were able to observe opening procedures. While 69% of the SDPs opened on time, 31% did not open on time, some of them up to two hours after the official opening time.

c) MCH services

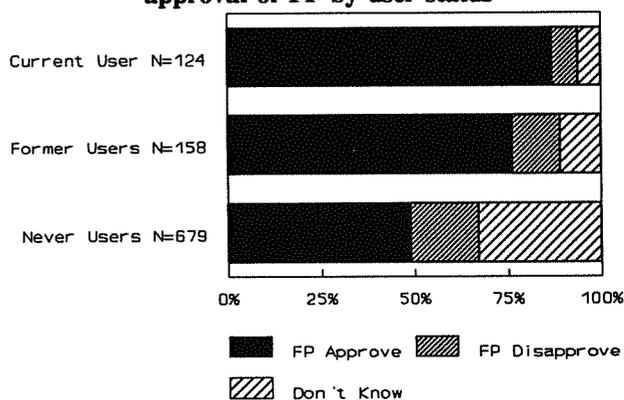
Family planning service delivery in Nigeria is, for the most part, provided at the same sites as MCH services; it is really only in the eight PPFN clinics sampled where there is specialization. Because of this it was felt important to interview clients who came to the clinic on the day for other health care reasons. There were 1,053 MCH clients interviewed during the study and four main reasons emerged as to why they attended the clinic. Most prominent was ante-natal care (30%), child health care (25%), child's illness (21%) and personal illness (13%). As may be expected, and as shown on Table 3, family planning is not the main service to be provided in most SDPs.

d) MCH and family planning client profiles

Although termed "MCH clients", 13% of those who responded and who had not come for family planning on the day of the visit were, in fact, currently using family planning; a further 16% were former contraceptive users. Moreover, of these 124 current users, only 77% of them knew that family planning was available at the SDP they were visiting, and the figures are even lower for former users (70%) and never users (61%). This suggests that service availability is not well known; it is hoped that the current national logo campaign will help to raise this level of awareness.

Approval of family planning by these MCH clients was high (87%) although, as may be expected, it is higher among current users than among never users. A similar trend was found when MCH clients were asked their perception of their husband's approval. As Figure 4 indicates, among the never users a substantial proportion do not know what their husband's feelings are, suggesting a lack of interest or discussion on the topic. This proportion was particularly high in Kano and Niger States.

Figure 4 MCH clients' perception of husbands' approval of FP by user status



National Situation Analysis, 1992

Knowledge of family planning methods amongst MCH clients was also high; for example, the percent who have ever heard of family planning (90% unprompted) is almost double that found in the Nigeria DHS. This is not particularly surprising as the situation analysis study is a clinic-based sample and the DHS is a population-based sample. Table 4 (overleaf) breaks down family planning knowledge¹⁵ by method and the data suggest that those attending MCH clinics are better informed about family planning than the general population. Of particular interest is the relatively high proportion (57%) who have heard of female sterilization.

¹⁵ These percentages are after prompting respondents.

Family planning clients were asked to give their first source of family planning information. Fifty-three percent of the respondents stated that they first heard about family planning from the clinics; a further 20% cited their friends or relatives and 16% the mass media¹⁶. This would imply that the clinics are an important source of family planning information in Nigeria and suggests that the family planning IEC activities undertaken at the clinics could be reinforced to ensure that the information received is relevant and correct.

Appendix 1 indicates a fairly even spread amongst the types of methods issued to new acceptors at the SDPs in the last month, with the pill being the most commonly provided. While this supports the DHS finding that the pill is the most commonly used modern method in the country, there is a discrepancy between the service statistics data displayed in Appendix 1 and the method distribution described by the DHS.

The situation analysis study only provides data for clinics and hospitals but the DHS indicates that half of the pill users interviewed obtained supplies from pharmacies and patent medicine shops¹⁷. Moreover, during exit interviews with 131 new clients, of the 106 who went away with a method, 51% accepted the IUD, 14% the pill, 13% the injectable and 12% the condom or spermicides; similarly, among the 259 continuing family planning clients interviewed, the methods being most commonly used were the IUD, the pill and the injectable. Most IUD users interviewed (87%) were coming for a follow-up and most pill (90%) and injectable (82%) users were coming for resupply. It is worth noting that 14% of the continuing users were coming because of problems with the method, the vast majority of whom (62%) were IUD users.

An examination of socio-demographic characteristics of the family planning and MCH clients interviewed, given in Appendix 2, shows some slight but interesting differences. For instance, the family planning clients are generally older than the MCH clients and have a higher mean parity. The implication is that women are perhaps seeking to space or stop child bearing later in their marriage, and after having had two or three children. The family planning clients are also better educated and are more likely to have jobs that bring in a financial income than the MCH clients. While a lower proportion of the family planning clients overall are Muslim (although this varies greatly by state), it is interesting to note that Catholicism does not seem to be a differentiating factor.

Table 4 FP knowledge among MCH clients attending 149 SDPs

	Percentage of 1053 clients
Ever heard of:	
pill	80
IUD	67
condom	71
spermicide	37
injectable	74
female sterilization	57
male sterilization	22
Norplant	8
NFP	30
traditional methods	29

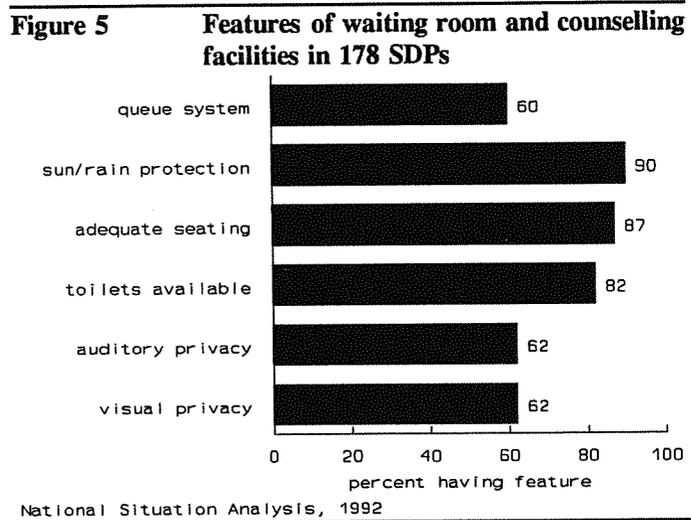
¹⁶ However, a study in three Nigerian cities in the late 1980's suggested that the mass media, and particularly television, could have a substantial effect on informing people about family planning. See Piotrow, P. *et al.*, "Mass media family planning promotion in three Nigerian cities" *Studies in Family Planning*, 21(5):265-74, 1990.

¹⁷ *op. cit.* Nigeria Demographic and Health Survey, 1992.

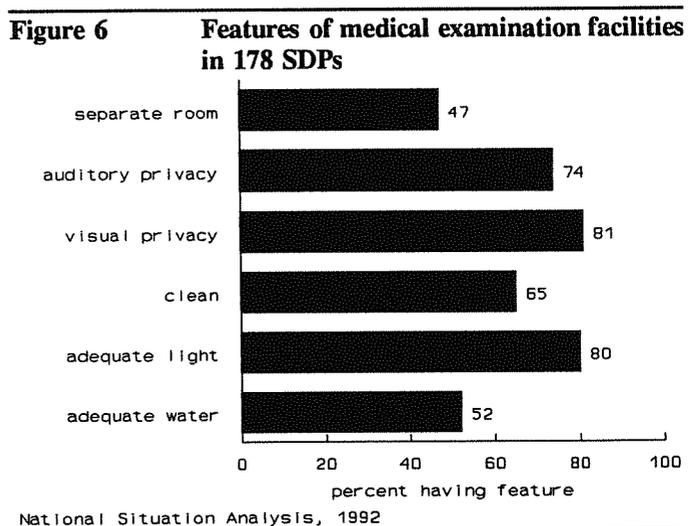
2. Functioning of the SDP sub-systems

a) Infrastructure, equipment, and physical facilities

What facilities, equipment and infrastructure are in place in an SDP offering family planning may be a determinant of the volume of clients attending and the quality of service offered. As part of the study, an inventory was taken at all except three SDPs (all in Niger State) to measure these items. The clinic waiting room and counselling facilities in 178 SDPs were observed and the findings are given on Figure 5. The majority of the SDPs have waiting rooms or areas that were protected against sun and rain, and most have adequate seating and toilets. Of some concern is that only about three in every five SDPs have auditory and visual privacy for counselling. This is a little worrying as this lack of privacy may inhibit some clients, and staff, from participating in a full and honest exchange of information during the counselling process. That only 60% of the SDPs have a queue system might be explained by the low level of service delivery noted for most of the SDPs; in this regard, there is often no need for clients to queue since there are usually not enough clients to form a queue!

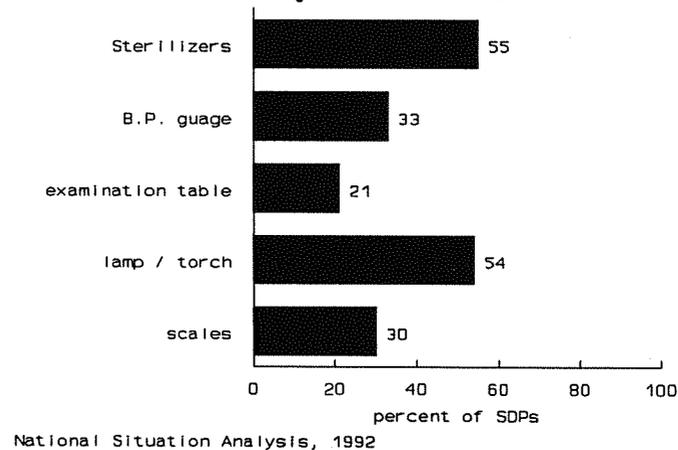


The features observed for the medical examination facilities at each SDP are given on Figure 6. As would be hoped, visual and auditory privacy are much higher for these facilities, but there is still about one quarter of all SDPs where a client does not have privacy during the medical examination; indeed, only 47% had separate rooms. It may be the case, however, that conditions necessary for visual and auditory privacy could not be observed during the visit (because no examinations were undertaken on that day), but that when medical examinations are carried out, arrangements are made to ensure privacy. For most SDPs there is adequate lighting for the medical exam, but only 65% of the exam areas could be regarded as clean and an adequate water supply was present in only half of the SDPs. There is clearly a need to improve the facilities available for undertaking medical examinations during family planning service delivery; it is also probably accurate to suggest that similar conditions exist for MCH service delivery.



An inventory of the availability of all equipment necessary for providing clinical family planning services was undertaken as part of the study. A full table of the findings is given in Appendix 3 and a summary of the availability of the key equipment is given on Figure 7. The results are rather worrying, particularly when it is remembered that these figures describe equipment that is available not solely for family planning but that may be shared for MCH and other service provision; these shortages, therefore, will affect the delivery of all other health care services provided in the facility.

Figure 7 Percent of 178 SDPs missing equipment necessary for clinical FP services



National Situation Analysis, 1992

For example, more than half of the SDPs did not have sterilizers and 61% did not even have sterilizing lotion. Over half had no lamp or torch, more than a third did not have a blood pressure gauge, and 30% did not have scales. With a quarter of SDPs not having an examination table or even chairs it is difficult to see how good quality service can be offered. Moreover, since these items are essential to ensure even a basic quality of care, any percentage of missing equipment should be regarded as significant; the percentages found here suggest that many SDPs are functioning under extreme limiting conditions.

b) SDP staff: experience and training

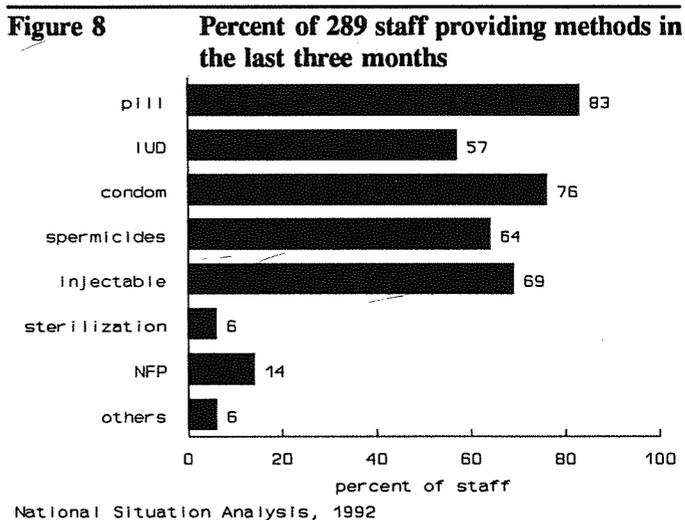
During the study attempts were made to interview all staff present at an SDP who were responsible for providing family planning services. However, as Table 2 above shows, staff interviews were completed in only 87% of SDPs. From the inventories completed at each SDP it was found that of the 23 SDPs where staff were not interviewed, six SDPs had no family planning staff at all. For the other 17 SDPs which were supposed to have family planning staff, either the staff were not present on the day of the visit (which may be possible given that ten of them have only one or two staff members) or it was not possible to interview those who were there.

On average, there are 4.7 family planning staff per SDP. However this mean value masks considerable variation as approximately 15% of SDPs have ten or more staff providing family planning, 20% have only one family planning provider and 6% have none; it may be more valid to state that the modal number of staff per SDP is two and the median three. Maintaining staffing levels is clearly a problem because 71 of the 181 SDPs (39%) had vacancies for family planning staff. Contrary to what might be expected, there is not a strong relationship between the number of family planning staff at an SDP and the number of clients served. For example, SDPs with only one provider served on average 122 new

acceptors in 1991 and those with three providers served an average of 379 new acceptors, yet those with ten or more staff served on average 274 new acceptors¹⁸.

There are various categories of staff working in the SDPs, the most prominent of which are midwives (70%), of which most are nurse-midwives (see Table 1). Community Health Extension Workers and Community Health Officers (11% of each) formed the only other meaningful categories of service providers. It seems that virtually no doctors are involved in routine family planning service delivery (only two were interviewed), but they are normally called upon for providing methods that require a greater degree of medical skill.

When asked how long they had been providing family planning services, 20% of staff interviewed said they had been providing services for less than one year while 22% had been working for more than five years; the mean length of time nationally was four years, but this ranged from 2.8 years in Anambra State to 6.1 years in Lagos State. However, when asked which methods they had provided in the last three months, the majority of staff (91%) had provided at least one of the six methods in the last three months and most had had experience of five of the six methods (see Figure 8).



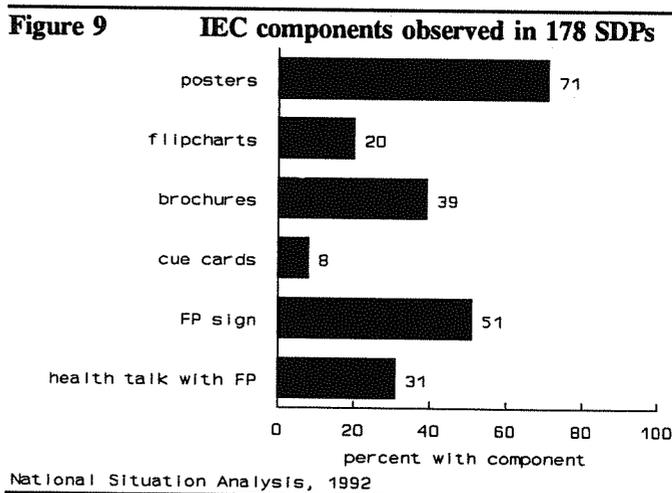
Fifty-three percent of staff interviewed said that they had had family planning in their basic health training, which probably reflects the recent inclusion of family planning in their responsibilities; 78% of 284 staff interviewed said they had been providing family planning for five years or less. The FMOH is dealing with this problem of under-trained staff through the introduction of the 'Clinical Service Provider' training course. This is the basic family planning up-date training for clinical staff and already 50% of those interviewed have received this type of training. Indeed, of the 47% of staff who did not have family planning included in their basic training almost all (91%) had subsequently had at least one course in family planning. The 13 staff who did not have any family planning training whatsoever worked in 13 separate SDPs; however in only two of those 13 SDPs were there no trained staff at all.

¹⁸ It could be argued that SDPs with missing service statistics are probably likely to have fewer clients, and also that SDPs with fewer providers are more likely to be missing service statistics. Because of this, the relationship might be stronger than appears.

Apart from basic and upgrade training, there are a few staff interviewed who have received specialist family planning training, most commonly in VSC counselling (11%) and motivation and outreach (10%). That staff require further training is confirmed in this study if quality family planning service delivery is to be expanded in the country; although 68% of staff felt that their training was adequate, 17% said that it wasn't adequate and 12% claimed that they were not trained in family planning at all.

c) IEC materials and activities

IEC materials are an essential sub-system of any family planning programme, particularly when the programme is new and levels of knowledge about contraceptives and reproductive health are low, as is the situation in Nigeria. For an effective family planning IEC campaign, therefore, one would expect IEC materials to be widely available, particularly at the SDPs. Figure 9 describes the IEC components observed in the SDPs visited. Posters were the most commonly found materials, with brochures, flipcharts and cue cards available in only a few SDPs. Health talks were observed at 56 SDPs on the day of the research team's visit, of which 48 included mentioning family planning.



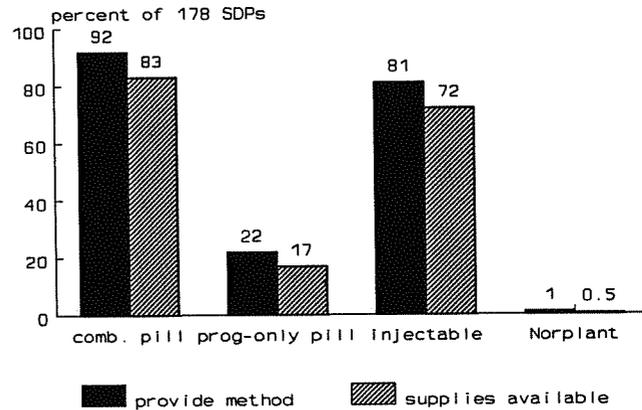
In addition to the apparently low level of IEC material availability, another observation was that only one half of the SDPs had a sign indicating that family planning services were available. In the predominantly Islamic state of Niger the proportion was only 16%, suggesting that this may be a deliberate attempt not to bring unwanted attention because of the sensitive nature of family planning in that State. This result may help to explain why almost one quarter (23%) of the MCH clients who were currently using family planning did not know that it was available at the SDP they were visiting.

In addition to their regular clinical duties, many staff said that they provided information on family planning outside of the SDP. Indeed, 60% stated that they regularly provided some form of outreach - both through home visits and through group sessions at community meetings, festivals, shows, schools, factories or other places. Moreover, 43% claimed to have done some outreach activity in the last month, including 16% doing home visits.

d) Contraceptive supplies and logistics

Availability of contraceptive commodities is an obvious prerequisite for service delivery *per se* and of the quality of service that an SDP can offer. During each visit to an SDP the researchers first asked which methods the SDP offered, and then physically counted the supplies for each method available in the clinic and storeroom. The results on Figures 10 and 11 show that all methods, except the progesterone-only pill, are widely available; Norplant is still being introduced on a trial basis. It is also important to note that female sterilization is available in as many as 14% of the SDPs visited.

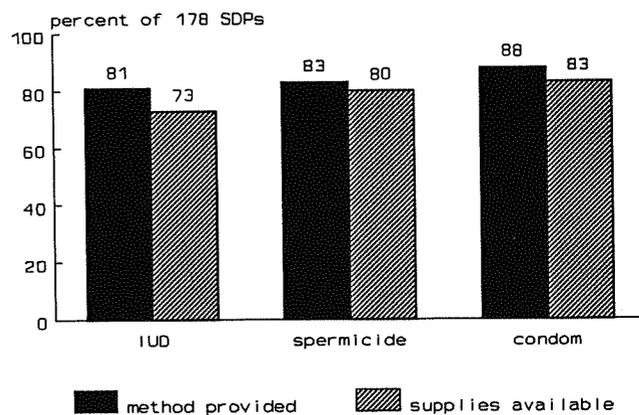
Figure 10 Availability of hormonal contraceptives in 178 SDPs



National Situation Analysis, 1992

On average, the number of methods provided per SDP was 4.5. However, there is considerable variation between SDPs and between states, ranging from 5.4 methods per SDP in Benue State to 3.3 methods per SDP in Niger State. A substantial proportion claim not to provide even the most common contraceptives. For example, 8% of SDPs do not provide the combined pill, 12% do not provide the condom, and 19% do not provide the IUD or injectable. The limited availability of methods in these SDPs, due to both non-provision and non-supply, is a constraint on the choice of methods that can be offered and thus on the options available to a client, not only when she first accepts, but more importantly if she needs to switch to another method for any reason.

Figure 11 Availability of IUDs and barrier methods in 178 SDPs



National Situation Analysis, 1992

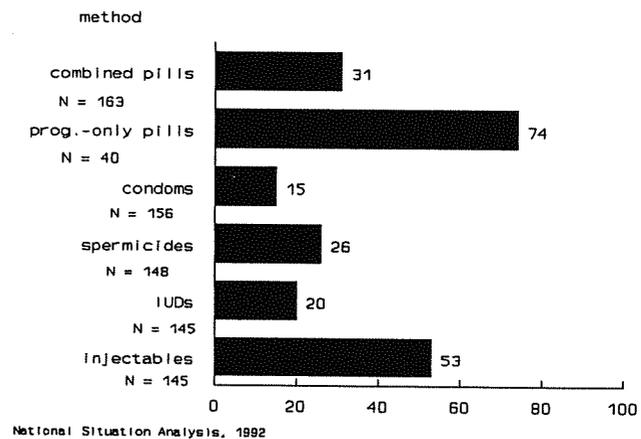
While 23% of the SDPs visited were found to stock six or more methods, 16 or 9% of SDPs indicated that they did not provide any methods whatsoever. Yet twelve of these SDPs had family planning staff in place, suggesting some underutilization of available staff. Not surprisingly, no clients were observed in these SDPs.

For all methods, the number of SDPs which claim to provide a method was greater than the number that actually stocked it at the time of the visit, indicating that there were some SDPs with a stockout on the day of the visit. Although supply of contraceptives is a common problem in most African programmes, in the SDPs visited, the discrepancy between

those that offer a method and those that stocked the method on the day of the visit was only 3-9% on average (see Figures 10 and 11), suggesting that method stockouts are not necessarily a major problem in Nigeria.

Figure 12 shows the percent of SDPs providing a method that had a stockout in the last six months. Progesterone-only pills and injectables seem to be particularly problematic, suggesting either that supply cannot keep up with demand, a poor ordering system exists, or simply that supplies are not available in the country. Given the apparently high proportion of women who use injectables (see Appendix 1) frequent stockouts of this method could have implications for client satisfaction and continuation. The more commonly used methods, such as combined pills, IUDs and condoms also suffer from stockouts but to a lesser degree.

Figure 12 Percent of SDPs providing a method having a stockout in the last six months

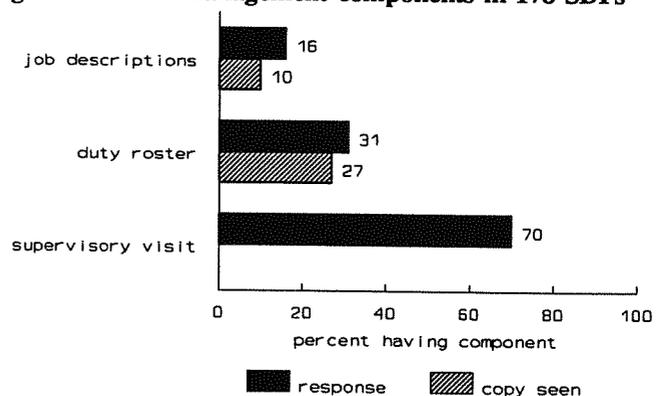


Commodities management is important for knowing when to reorder more supplies and also to ensure correct storage of supplies. Information was sought from the SDPs as to whether an inventory of the commodities was available as well as on other management and storage practices. Among the 181 SDPs, 76% had an inventory of their commodities, 86% had a reordering system and 73% had adequate storage. Because commodities have expiry dates, one way to ensure that SDPs do not store expired drugs is to adopt a storage system by expiry date. 69% of the SDPs stored commodities by date which implies that over 30% of the SDPs could store commodities that have expired without being aware of the fact.

e) Management and supervision

It is difficult to measure management and supervision activities directly and so indirect indicators were used. Figure 13 describes the three management components measured, i.e., the availability of a job description for staff, a duty roster, and whether there are supervisory visits made to the SDP. For the first two items, the person in charge was asked if they were available and then to show the researcher a copy. Most of the SDPs have neither duty rosters nor job descriptions. Some explanations

Figure 13 Management components in 178 SDPs



National Situation Analysis, 1992

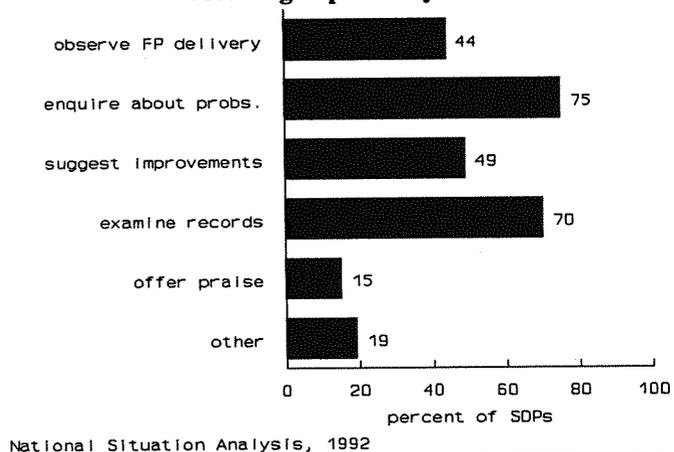
may be that job descriptions are not necessary because staff know what they are supposed to be doing, and that duty rosters are not appropriate in small SDPs where there may only

be one or two staff; even allowing for these situations it would appear that these, and other, management issues require some attention.

Although only 70% of SDPs reported receiving supervisory visits, this would seem to be quite good in comparison with other African countries. Supervision would seem to be a little better in hospitals than in other SDPs in that 77% of hospitals have received supervisory visits, one-third experiencing three or more in the last six months. This compares with the other SDPs which reported 65% having visits, 23% of them three or more.

When asked what actions the supervisors undertook during their visits, the persons in charge gave the responses described on Figure 14 (multiple responses were possible). In the 124 SDPs that reported having supervisory visits, the most commonly cited actions were examining records and enquiring about problems; in less than half the SDPs did supervisors observe service delivery activities or suggest improvements and in only 15% did the supervisors offer praise to the staff. Although on the one hand this suggests that supervisors are more inclined to search for faults than to provide positive support, the fact that in 75% of cases they enquired about problems suggests that they do seek feedback from the staff. Whether this table reflects the type of activities that supervisors are supposed to undertake is not known, but it would appear that when they do make visits they are fairly active and do not see their role as uni-dimensional.

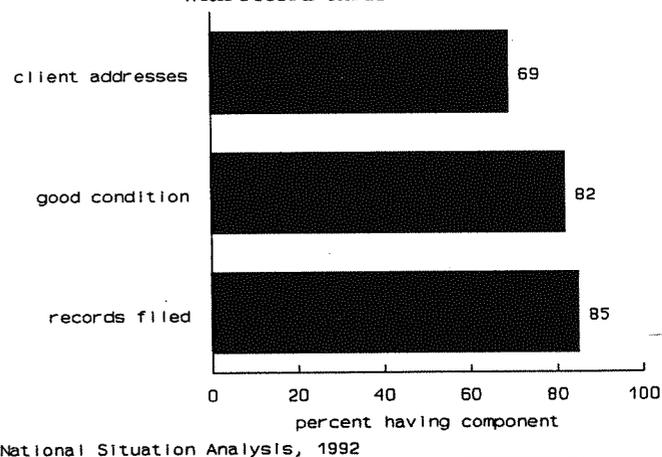
Figure 14 Supervisory actions reported in 124 SDPs receiving supervisory visits



f) Record keeping and reporting

Record keeping was generally a positive feature of most SDPs. Separate record cards were kept for each client in 89% of the SDPs; 85% of the SDPs sent their family planning reports regularly to the headquarters while seven out of every ten SDPs kept a daily register. As can be seen on Figure 15, 82% of 159 SDPs with record cards have records that were in good condition and were properly filed. A significant proportion of SDPs (31%) did not record clients' addresses in sufficient detail to be able to follow-up these clients. However,

Figure 15 Quality of record keeping in 159 SDPs with record cards



in many cases this may reflect a conscious decision by the client to give an inaccurate address to maintain privacy.

Although the records for individual clients were generally quite good, the aggregate service statistics for the SDP were in poor condition. Indeed, in many cases the visit of the research teams turned into an exercise in organizing and writing up the statistics. It became apparent that many SDP staff do not know how to keep records and are not interested; the research teams themselves often had to go through the records and show the staff how to complete the forms. Training in record keeping and interpretation of the results is therefore a key need in many of Nigeria's family planning SDPs¹⁹.

In addition to assessing the quality of service statistics, the frequency with which family planning reports were sent by SDPs to some other office was examined. Of the 178 SDPs, 152 (i.e. 85%) regularly sent reports although the reasons why the other 26 SDPs did not send reports was not clear. Of the 152 SDPs that had sent reports, the majority (84%) had sent a report within the last two months, suggesting that the SDPs are fairly timely with their reporting. While report writing is thus clearly a high priority, only 37% of the SDPs which send reports said that they receive any feedback on them.

¹⁹ The most recent edition of *The Family Planning Manager* (May 1992), issued by the USAID-supported FPMD Project, is entitled "Using service data: Tools for taking action". It reviews how SDP staff can record, analyse and use service data and features a case study drawn from Nigeria, making it particularly pertinent.

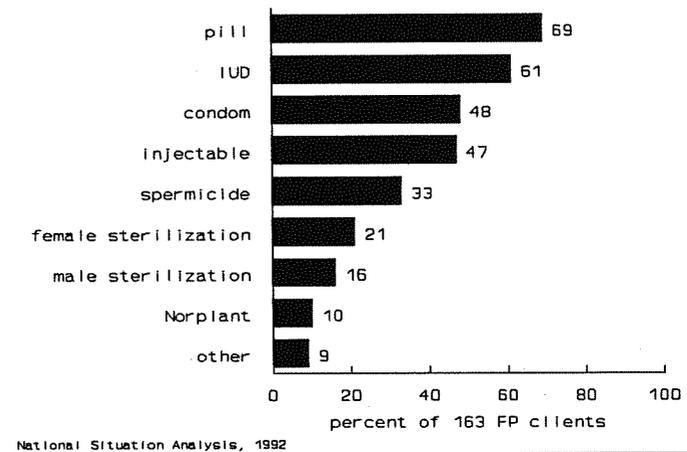
3. Quality of Care at SDPs

a) Choice of methods

A pre-requisite of being able to offer methods is that the methods be available at the SDP and that the SDP be open; these issues were discussed previously. However, even if methods are available at an SDP they may not be discussed with a client. Figure 16 shows the methods observed to be discussed with new and switching family planning clients.

While providers discussed the pill and IUD with two thirds of the clients, the condom and injectable were mentioned during only half of the counselling sessions and spermicides in one third of the sessions. The emphasis on the pill and IUD may be because these methods were available at the providers' clinics or that they knew more about them. Interestingly, female and male sterilization were also mentioned in about a fifth of the cases. This may reflect the fact that providers were "over-performing" during the interactions due to the presence of the observers.

Figure 16 Percent of 163 new and switching clients with whom methods were discussed



National Situation Analysis, 1992

When the number of methods discussed with each of the 121 new clients was examined a wide range of experiences was found. Although the modal number of methods discussed was only one (for 28% of new clients), the mean and median numbers of methods discussed were 3.5 and 4 respectively, indicating that many clients actually had several methods discussed with them; indeed one quarter of new clients had six or more methods discussed during the counselling session. However, this needs to be balanced by the observation that in twelve cases (i.e 10%) no methods at all were discussed with the new clients. There were also substantial variations between states, with the mean number of methods discussed being as high as six in Anambra State and as low as two in Niger and Osun States.

One potential barrier to the methods discussed with clients and thus on the choice offered is that there may be actual or perceived restrictions on methods that influence whether or not a provider is able and *willing* to discuss and provide a particular method. When asked about their perceptions of four such restrictions, providers gave the responses shown in Table 5 overleaf. The methods for which there are the most restrictions are the combined pill, injectables and sterilization. Specifically, age seems to be perceived as a restriction for combined pills, injectables and sterilization, with approximately half of the respondents identifying this restriction for these methods. Parity is also seen as a restriction, particularly for injectables and, as may be expected, for sterilization. Marital status is not seen as a restriction generally, although interestingly the method for which most staff mentioned this restriction was the IUD, particularly in Lagos State. Similarly, during the fieldwork there was much discussion of the need for spousal consent, not only in approval

Table 5 Percent of 289 staff interviewed perceiving restrictions on method provision

METHOD	Age	Number of children	Marital status	Consent of spouse
Combined pill N=267	55	12	7	23
Progesterone-only pill N=65	17	8	5	14
Condom N=258	4	1	4	18
Spermicides N=244	3	4	4	19
IUD N=248	12	18	19	19
Injectable N=245	49	51	11	22
Female Sterilization N=49	43	51	18	31

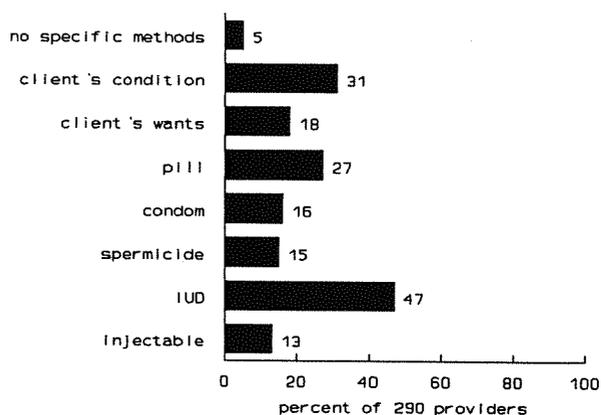
N = the number of staff located at SDPs where the method is available.

of family planning practice in general but also in the specific method choice. The proportion of staff that perceived this as a restriction varies between methods, being highest for female sterilization.

There is considerable variation between States in the proportion of staff reporting of restrictions, which probably reflects differences in policies and cultures. For example, in Benue and Kano States, approximately one fifth of staff report age restrictions for combined pills whereas the proportions for for Anambra and Osun are over two thirds. In Niger and Kano States, between one half and three quarters of staff report spousal consent restrictions for every method. This contrasts with less than 10% for each method in Osun and Lagos States. Thus, in some states providers are reluctant to offer hormonal methods to certain women whereas in others the absence of spousal consent is a strong barrier to offering any method at all.

The issue of method choice was further explored by asking providers what methods they would recommend for spacing and stopping births. Figures 17 and 18 describe the results (multiple responses were possible). The IUD is a clearly preferred option for birth spacing, with the pill as the second favourite method. Substantial, although minority, proportions said that their recommendation would depend on the client's condition or her preference.

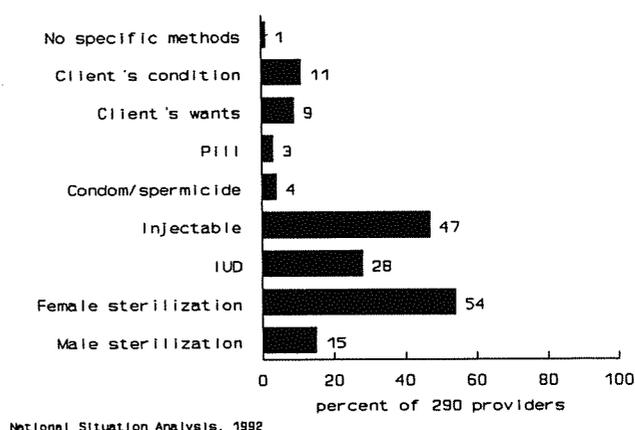
Figure 17 Percent of 289 providers recommending methods for spacing purposes



National Situation Analysis, 1992

The injectable is seen as a long-term method rather than a spacing method as shown by both of these Figures. Moreover, almost twice as many providers see the injectable as a long-term method when compared with the IUD, and yet the latter has a far longer duration of effect. It should also be noted that over half of the providers recommend female sterilization and 15% recommend vasectomy for stopping childbearing. This suggests that providers are generally not biased against permanent methods, although to what extent they will actually suggest the method is not so clear (see later). The client's condition and preferences did not seem to be so important a consideration for women seeking to stop childbearing.

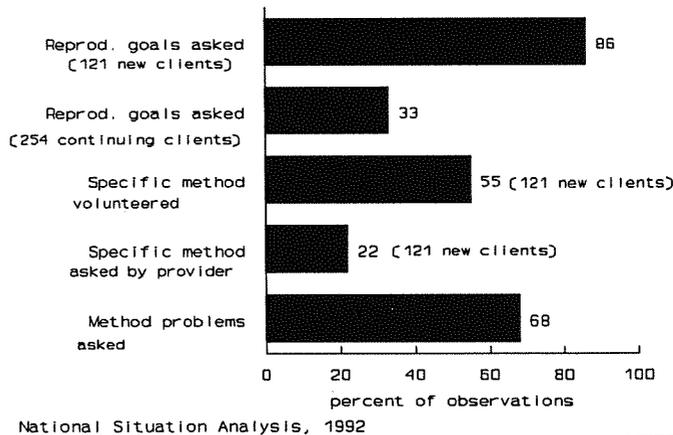
Figure 18 Percent of 289 providers recommending methods for stopping childbearing



b) Provider-client information exchange

Two components of the exchange of information were measured; the attempt made by providers to understand client's needs, and the information given to clients. In assessing whether providers attempt to understand clients' needs, the questions that the providers asked the clients during counselling were observed; Figure 19 describes these observations. Overall, in only half of the cases observed did the provider ask the client about her reproductive goals and plans, but this clearly varied depending on whether the client was new or continuing; the relatively few continuing clients asked whether their reproductive plans had changed since their last visit suggests that many providers do not feel it necessary to find out this information.

Figure 19 Provider actions observed during counselling with 395 new and continuing FP clients



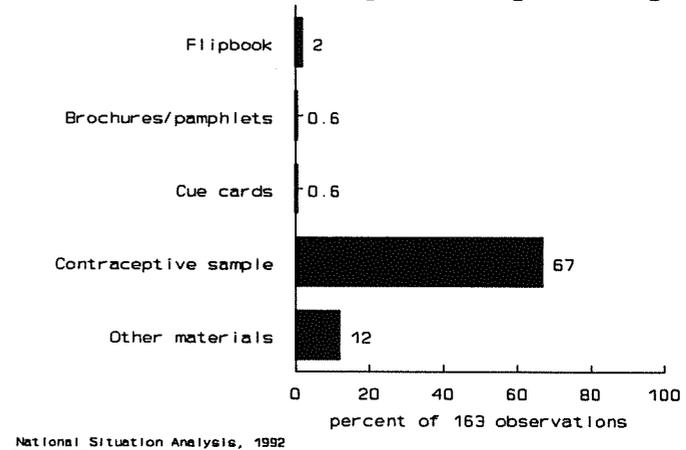
Of the 121 new clients observed, 55% indicated themselves a preference for a particular method, suggesting that they were already quite aware of family planning before coming to the clinic, probably having heard about it from other users. The majority of these clients (56%) requested the IUD; other methods requested included the injectable (21%) and the pill (14%). Of those not volunteering a preference, however, only 22% were asked by the provider whether they had a preference for a method. Thus, of the 121 new clients observed, 35% did not indicate a preference and were not asked by the provider.

Of the 254 continuing users observed, over two thirds were asked if they were having any problems with the method. Of the 172 who were asked, 64% were able to discuss how to manage the problem with the provider.

Two ways of imparting information about family planning at the SDP were assessed; the group health talks and the counselling sessions held with individual clients. Health talks are expected to be carried out before clinic sessions begin in most health clinics, but only 31% of the SDPs visited held a talk on the day of the visit. Of the talks observed, the vast majority (86%) did include the topic of family planning and in over half (61%) the audience asked questions or discussed the family planning issues raised. Evidence from an operations research study in Kenya²⁰ suggests that the daily health talk is a "missed opportunity" for family planning IEC and has the potential to be a powerful mechanism through which family planning messages can be communicated; this is one IEC activity that would seem to be easily strengthened in Nigeria.

In an individual counselling session not only are providers supposed to elicit information from clients, they are also expected to convey information to them about the methods. It appears, however, that IEC materials are rarely used during client counselling. As Figure 20 shows, virtually the only aids used during counselling are contraceptive samples. The 'other materials' refers primarily to the staff member referring to or using a poster on the wall and occasionally a model of reproductive organs. Whether this reflects an absence of suitable materials, or an unwillingness or lack of knowledge of how to use those materials that do exist is unclear.

Figure 20 Percent of 163 new and switching FP clients with whom IEC materials were observed being used during counselling



During the interactions observed, the type of information given to the clients was noted. Although, as Figure 16 above described, a number of methods were discussed with most new and switching clients, it is clear that clients were not given information equally on each aspect of the methods. For example, although, pills were mentioned to 69% of the new and switching clients, of those to whom it was mentioned 86% were told how it works, two thirds how to use it, and only about one half were told about its side-effects, effectiveness and contraindications (see Figure 21 overleaf). A similar pattern is found for all the other methods. This may indicate either that providers were unable to explain the details of certain

²⁰ An operations research study in Kenya found that including family planning in the health talk was effective in raising the number of new and continuing users; see Mwita, J *et al.*, "Eliminating missed opportunities for family planning education in MOH MCH/FP clinics", Paper presented at the Workshop on Research Results and Implications for Collaborative Action, Population Council, Nairobi, Kenya, 1992.

methods because of a deficiency in their knowledge or counselling skills, or that they did not feel it important to go through all the details of every method, but rather give only what they considered the most important aspects (how to use it, how it works). A project to train providers in information-giving in Ogun State²¹ showed that trained providers were better at giving accurate information, using visual aids and summarising information, but the training didn't seem to affect their ability to explain the benefits of a method or the consequences of switching methods.

Among IUD acceptors for whom the observation and exit interview could be linked, the discrepancy between what the observer heard about information provided and what the client reported was examined. As Figure 22 shows, while the observers indicate that the information provided to clients is incomplete, the clients seem to think that they are being given sufficient information. For example, 87% of IUD acceptors believe they were told about side effects and 77% how to manage them, while the observers report that in fact 57% of IUD acceptors were told about side effects and only 40% how to manage them. Even allowing for the possibility of courtesy bias by the clients in responding to enquiries about what they were told by the provider, these are large discrepancies.

c) Technical competence

Technical competence was assessed by observing the medical procedures followed by providers when delivering services. For those methods requiring medical examinations, that is, new IUD and hormonal method acceptors, adherence to these procedures was examined. Figure 23 (overleaf) describes the actions observed during medical examinations with 48 new IUD acceptors. Because IUDs are generally contraindicated for women with or at high risk

Figure 21 Type of information observed to be provided to 112 new and switching clients about the pill

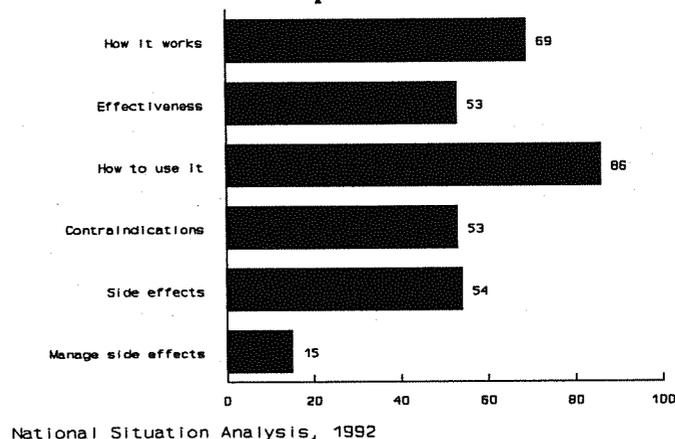
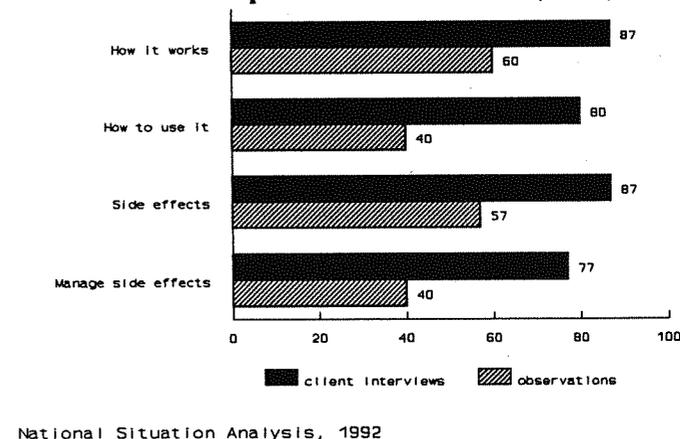


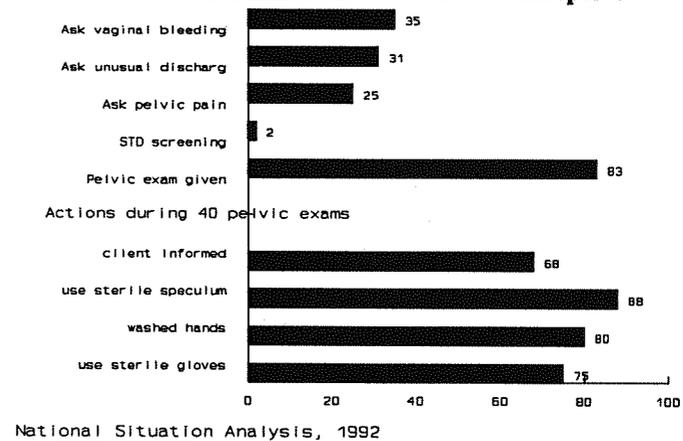
Figure 22 Discrepancy between observer and client reports on information given to IUD acceptors about the method (n=30)



²¹ Young-Mi Kim *et al*, "Improving the quality of service delivery in Nigeria" *Studies in Family Planning*, 23(2):118-127, 1992.

of reproductive tract infections, it is often considered appropriate medical practice to question potential IUD clients about symptoms and to perform a pelvic examination. Yet only 35% of IUD acceptors were asked about unusual vaginal bleeding, 31% about unusual discharge and 25% about pelvic pain. While it is expected that all IUD acceptors would be given a pelvic exam, 17% did not have one. Of the 40 clients who did get a pelvic exam, for four of them something abnormal was discovered and yet they still had an IUD inserted.

Figure 23 Provider actions observed during medical examinations with 48 IUD acceptors

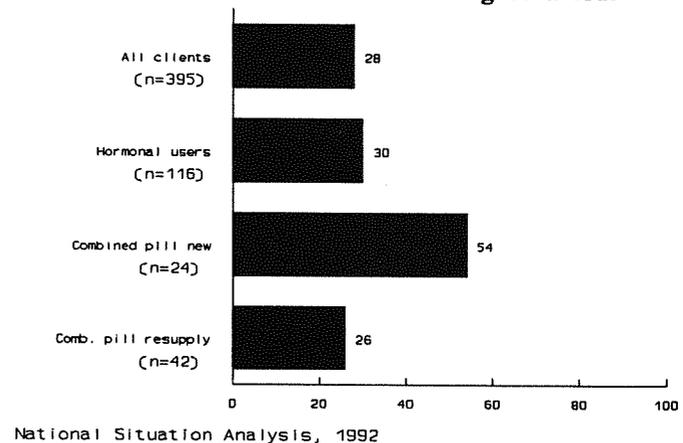


It is also good practice to inform clients what to expect before performing a procedure. During the 40 pelvic examinations observed, 68% of the clients were informed by the provider a pelvic examination would entail. Not all providers followed strict aseptic techniques, with 12% not using a sterile speculum and 20% not washing their hands. Although 98% used gloves, nearly one-quarter did not use sterile gloves. Equipment shortages may well contribute to this as 56% of SDPs lacked a sterilizer, 62% lacked sterilizing lotion, 48% lacked non-disposable gloves and 65% lacked disposable gloves.

For clients contemplating hormonal methods, it is usually considered necessary to check for hypertension through measuring the client's blood pressure. However, for over one third of new hormonal method acceptors and virtually all resupply users (94%), blood pressure was not taken. Again, this may in part be due to the fact that 34% of the SDPs did not have blood pressure gauges, but regardless of the reason there is a possibility of contraindicated clients being provided a hormonal method.

Another indication of provider competence is whether clients are asked whether they are breastfeeding. For lactating clients - particularly those under 12 months postpartum - hormonal methods, especially combined pills, are not generally recommended because they reduce the quantity of milk produced. Figure 24 indicates that fewer than one-third of the 395 clients observed were asked about or were seen to be breastfeeding by the provider. However, one half of new combined pill acceptors were asked or observed to be breastfeeding.

Figure 24 Percent of family planning clients asked about their breastfeeding behaviour



In the exit interview, clients were questioned about whether they were breastfeeding and 23% of all clients were breastfeeding. Combined pills are generally not considered the method of choice for breastfeeding clients, regardless of the

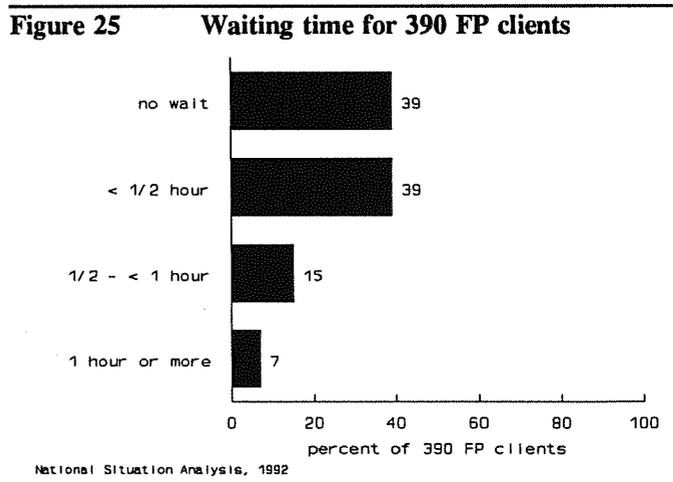
number of months postpartum, yet Figure 24 indicates that 28% of combined pill users (both new and continuing) were currently breastfeeding. More thorough questioning of clients during the counselling session may help to avoid these potentially risky situations.

A further indicator of technical competence measured was whether, in the view of the experienced nurse-midwife observer, the client received an appropriate method. Out of the 379 new and continuing family planning clients observed, the observers judged that 87% of them received an appropriate method, and for only 8% was it felt that they received an inappropriate method; in 5% of the observations it was not clear.

d) Client / provider relations

Client / provider relations were measured in two ways; the providers' interpersonal skills, and the amount of time spent waiting and with the provider. Much of the emphasis in enhancing the quality of services offered is placed on the nature of the relations between the provider and the clients. Interpersonal skills were measured through the welcome given to the client and the invitation to ask questions at the end. Virtually all clients (97%) were observed to be given a friendly greeting, but only one third were asked at the end of the session whether they had any questions. This may reflect a feeling by the provider that the session had covered all possible issues.

The time clients had to wait before they could see providers can be an important factor affecting the acceptability of family planning services and waiting times have been a problem in some African programmes, notably in Kenya²². As can be seen from Figure 25, when asked how long they waited, 39% did not have to wait at all and a further 39% waited for less than half an hour; very few clients had to wait for more than one hour. Moreover, when asked what they felt about the waiting time, only 19 clients (5%) said that they felt they waited too long.



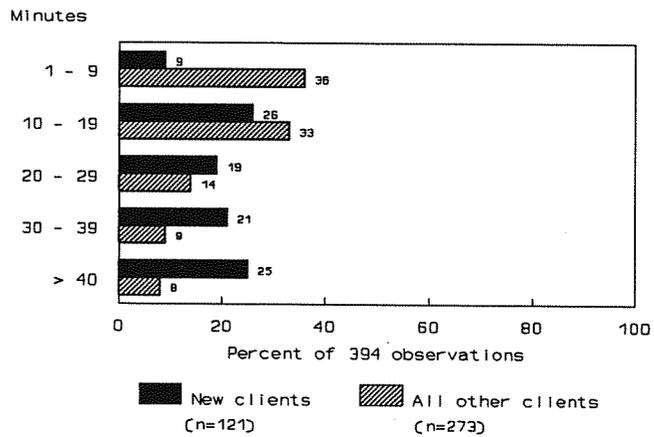
Somewhat surprisingly, clients attending the busy SDPs (i.e. the 19% of SDPs which served 75% of new acceptors (see Figure 1)) were less likely to have to wait for more than

²² An operations research study on this topic has recently been completed by the Africa OR/TA Project; see Ocholla-Ayayo, A. *et al.*, "Reducing client waiting time in Kenyan MOH MCH/FP clinics", Paper presented at the Workshop on Research Results and Implications for Collaborative Action, The Population Council, Nairobi, Kenya. 1992. Also The first edition of *The Family Planning Manager* (March 1992) reviews the client flow analysis method for assessing waiting times and possible solutions to the problem.

one hour. Only 3% of clients attending busy SDPs waited more than one hour compared with 11% of clients attending the less busy clinics. In other words, the more heavily utilized SDPs had shorter waiting times, suggesting that they are more efficient in processing clients.

As would be expected, the duration of the interaction itself varies depending on whether the clients were new or continuing (Figure 26). For new clients, the mean duration of the interaction was 33 minutes whereas for other clients, most of whom were there for resupply or check-ups, the mean duration was 19 minutes, which is still a substantial portion of time to spend with a client. Obviously in those clinics where there are very few family planning clients (and that includes the majority of those visited) the providers have more time available to spend on clients, but in the busier SDPs the research teams observed several clients being attended to simultaneously, but individually, by one or more providers. It is in such situations that some clients find themselves in an interaction that can last up to three hours; indeed among the 394 clients observed, 13 of them (3%) were attended for over two hours.

Figure 26 Duration of 394 observed FP interactions



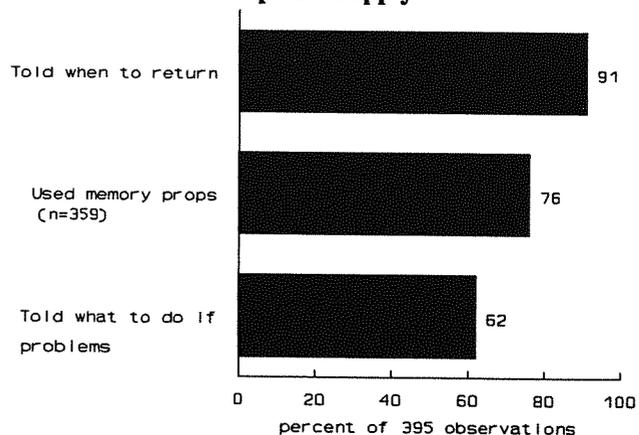
National Situation Analysis, 1992

As may be anticipated, clients attending the less busy SDPs had shorter interaction times than those attending the busier SDPs. This pattern is particularly pronounced among continuing clients. Resupply, switching, follow-up and other continuing clients attending the less busy SDPs spent on average 23 minutes with providers whereas their counterparts in busier SDPs spent 15 minutes with providers. New clients who attended the less busy SDPs had a mean interaction time of 34 minutes, compared with 30 minutes for those who attended the busier SDPs.

e) Mechanisms to encourage continuity

One component of service delivery that is seen to be important in the drive to encourage continuation rather than simply acceptance, is what the provider tells the client about follow-up and resupply. Obviously different methods have different requirements if a client is to use it continuously, but there are certain actions that a provider should take that can encourage method continuation. As Figure 27 shows, a significant proportion of clients were told when

Figure 27 Provider actions observed with 395 new and continuing FP clients concerning follow-up or resupply



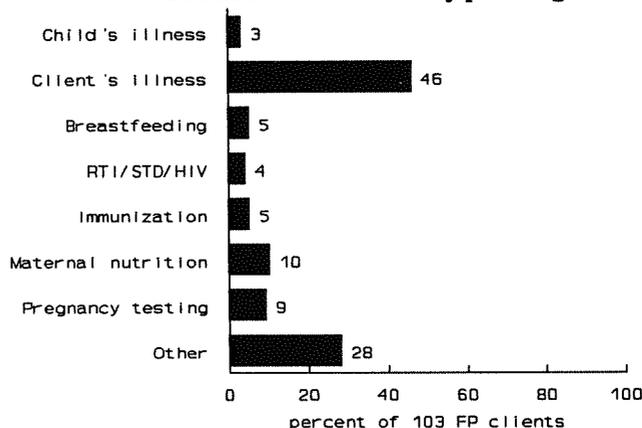
National Situation Analysis, 1992

to return and with most of these a memory prop was used to assist them remembering the date. However, considerably fewer clients were told what to do if they had problems. Moreover, of the 65 new acceptors of pills, condoms, injectables and spermicides (i.e. methods requiring resupply) 43% were not told where to go for resupplies, a problem that could potentially undermine the likelihood of the client continuing to use the method.

f) Constellation of services offered

Family planning services in Nigeria, certainly in the public sector, are provided at the same site as MCH and other health services. This does not necessarily mean that there is integration as family planning may still be provided separately from the other health care services. During the 395 observed interactions with family planning clients, other health issues were discussed with 103 clients, that is, in 26% of the cases. As Figure 28 indicates, in almost half of these cases the clients wanted to discuss an illness, with a further 10% wanting to discuss nutritional issues and 9% wanting a pregnancy test. These observations suggest that those providing family planning services do not mind discussing other health issues. The main issue here, however, is whether it is possible for the provider to take any immediate action on the issues discussed or whether the client will have to have a separate consultation.

Figure 28 Other health issues observed being discussed with 103 family planning clients

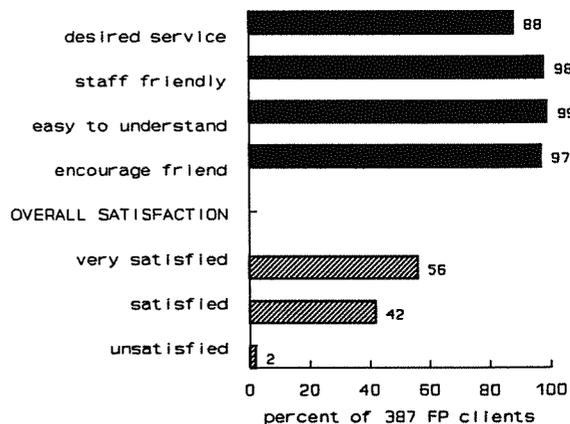


National Situation Analysis, 1992

g) Client satisfaction

The satisfaction of the clients is ostensibly a function of the quality of service provided. However, client satisfaction is difficult both to conceptualise and to measure. For this study, each client was asked to rate the service they had received in terms of a number of items; Figure 29 summarises the results. As has been found in studies in other African countries, clients tend to be highly complimentary about the service they received, saying that they were satisfied with the service, found the staff friendly and easy to understand and would encourage a friend to use the SDP if she wanted family planning.

Figure 29 Indicators of client satisfaction for 387 FP clients



National Situation Analysis, 1992

It is somewhat hard to believe that level of overall client satisfaction is as high as this given that the quality of service received was so variable²³. Possible explanations given by the research teams for this include both the 'courtesy bias' common in many African cultures, and the low level of expectations of family planning clients. The latter is particularly relevant in this situation where family planning is such a new service that clients have very little basis for comparing their perception of satisfaction; for many, therefore, to receive any service at all is a satisfactory outcome.

An indirect way to measure client satisfaction is to determine whether those who indicated or were asked by the provider if they had a method preference actually obtained what they desired. Among the 83 clients for whom a particular method preference was observed at the beginning of the counselling session, only 54% obtained the method they had indicated. Furthermore, during the exit interviews, clients were asked whether, at the time they accepted the method, there was some other method they had really wanted to use; 23% of clients responded that they would have preferred another method. The IUD was the method given most frequently to these clients; approximately half of the 91 clients who would have preferred another method had an IUD inserted, 15% received an injectable and 14% received the combined pill. It has been shown elsewhere that clients who receive their preferred method are more likely to continue using it than clients whose choice, for whatever reason, is not granted²⁴. These findings suggests, therefore, not only that perhaps not all clients are as satisfied as they say but also that the possibility of provider bias is demonstrated.

²³ A similar finding was found in the Situation Analysis study of the Nairobi City Commission SDPs, see The Nairobi City Commission, The Population Council and Pathfinder International, A Family Planning Situation Analysis Study of the Nairobi City Commission CLinics, The Population Council, Nairobi, Kenya, 1991.

²⁴ Pariani, S., D. Heer & M. Van Arsdol, "Does choice make a difference to contraceptive use: Evidence from East Java", Studies in Family Planning 22(6): 384-390, 1991.

IV. PROGRAMMATIC RECOMMENDATIONS

The results presented above have also been dis-aggregated by State, and individual reports for the six states are available from the Principal Investigator. The preliminary results were presented at a national seminar held July 30th, 1992 and during that seminar recommendations for policy and programme development and for further operations research were made. These are presented below.

1) Recommendations for Strengthening Service Delivery Sub-systems

The following sub-systems were identified as needing priority attention:

- Contraceptive supply and logistics management
- Clinic infrastructure
- Equipment available for service delivery.

Specific recommendations for further action were made for these and other sub-systems as follows:

- i) Contraceptive supplies and logistics management:
 - FMOH, working in collaboration with FHS, should identify and train logistic officers at the Federal, Zonal and State levels;
 - a survey should be conducted to determine the patterns of distribution.
 - FMOH to request for more UNFPA supplied commodities based on the high level of usage, particularly injectables.
- ii) Clinic Infrastructure:
 - facilities should be upgraded to an established standard;
 - existing infrastructure should be surveyed to determine what improvements are required in each state, LGA or district.
- iii) Equipment available for service delivery:
 - emphasis should be placed on better maintenance of existing equipment;
 - equipment should be distributed to facilities where they can be utilized by trained personnel;
 - there should be flexibility of in the use of existing equipment.
- iv) Training and competence of staff:
 - a needs assessment should be conducted to determine the number and location of staff already trained so as to establish future training needs;
 - in-service (i.e. on the job) training should be encouraged;
 - standard criteria should be developed to identify suitable personnel for further training;
 - trained staff should be given every opportunity to practice their skills;
 - training institutions should be strengthened to provide both pre-service, in-service and refresher training.

- v) IEC materials and counselling:
 - IEC posters should be attractive and of good quality;
 - IEC posters should be posted in places other than the clinics such as the town halls and other community centres.

- vi) Management and Supervision:
 - supervisory system at the State and LGA levels should be strengthened through training;
 - revise and make available a standardized supervisory checklist to States and LGAs;
 - health professionals should be encouraged to work collaboratively to ensure maximal utilization of scarce resources for supervision.

- vii) Record Keeping and Reporting:
 - training should be provided on data gathering, analysis and utilization at the SDP level.

2) Recommendations for Improving Quality of Care

- i) A number of factors were identified that may inhibit the choice of family planning services available to a client at the SDPs. These include:
 - lack of equipment available to provide all methods
 - lack of motivation or a negative attitude towards family planning by service providers
 - the provider choosing the method for the client because of their assumption that the method is good
 - certification regulation by training institutions for 10 IUD insertion
 - availability of methods
 - service providers values e.g age/parity restrictions.
 - poor counselling and lack of IEC materials prevents full information being given to clients
 - lack of standard of practice
 - spousal consent is needed, or perceived as needed, for some methods

Recommended actions to address these issues are:

- training for staff in counselling should focus on side effects and contraindications;
- create awareness of amongst policy makers of the potential for community mobilization;
- all health personnel to have basic training in family planning to improve attitudes towards family planning.

- ii) The study showed that clients did not always receive adequate and appropriate information about the methods available. To improve this it was recommended that the delivery of family planning information be improved by:
- providing more audio visual aids and other IEC materials - songs, jingles, drama clips (in local languages) - at the SDP;
 - training health workers to take note of the language that is acceptable to their community;
 - involving NGOs, VHWs, satisfied clients and others at the community level who can positively promote family planning and give accurate information.
- iii) It was also observed during the study that the technical procedures followed by service providers for medical and pelvic examination were not always sufficient. Specific areas of weakness were:
- STD screening
 - history taking, especially for vaginal bleeding
 - non compliance with aseptic techniques
 - pelvic exams
 - physical exams, especially blood pressure measurement

To improve this it was recommended that:

- refresher training be provided regularly for all family planning providers;
- SDPs be adequately equipped;
- management and supervision of staff be strengthened through training.

- iv) The average waiting time was found to be satisfactory overall, although where waiting time is long it was recommended that action be taken to:
- ensure more service providers are at the SDP
 - ensure better utilization of service providers' time
 - better management of staff time by the clinic manager
 - provide back up staff where there is only one provider.

3) Recommendations for Policy Development and Funding Requirements

- i) The overall focus for implementation of the national population programme should be maintained. However, different strategies should be considered based on locally prevalent circumstances. For example, even though Federal guidelines are that MCH/FP services be integrated, the findings of the survey suggest that further efforts should be made to strengthen integration of MCH/FP at service delivery points. Different approaches will be needed for primary and secondary care levels.
- ii) All cadres of health professionals should be exposed to family planning during their basic training. This would help to solve the problem of disruption of service delivery caused by frequent transfers and shortages of trained family planning providers.

- iii) The mechanism for managing and administrating technical support and supervisory roles at the level of both the States and LGAs must be clarified as there is some confusion as to the roles at each level.
- iv) Efforts need to be strengthened in mobilizing community level support for family planning services. A CBD system is one approach to this and efforts to develop CBD programmes should be intensified.
- v) Family planning messages need to be integrated into PHC-related communication strategies including safe motherhood - maternal child health initiatives and income generating / economic enablement strategies for women.
- vi) Provision of more trained female providers to provide services in those parts of the country where they are not currently operating e.g some Northern States.
- vii) There is a need to review the policy which does not allow clinics to operate an imprest accounting system so that managers at the SDP can have access to costs recovered by their clinic. The recently introduced guidelines on budget lines for family planning need to be emphasized and should be revised upwards.
- viii) With respect to the contributions that Donor agencies might make, it was recommended that they focus their assistance on:
 - basic and refresher training in family planning
 - support for an OR-type approach to programme evaluation and development
 - enabling a phased take over by government of the major subsystems which they currently support, e.g CBD systems, equipment and cost recovery mechanisms.

4) Further Operations Research for Service Delivery Problems

- i) The following components of the service delivery sub-systems would benefit from further operations research to answer some of the questions raised by the results of the situation analysis study:
 - How detrimental is the present supervision system to family planning service delivery? (i.e only 69% of SDPs received supervisory visits and limited supervisory actions were taken during visits).
 - Why are record keeping and reporting not adequate?
 - How can records be used to improve the quality of care?
 - Why is the situation regarding the availability of commodities so bad when a functioning re-ordering system exists?
 - Why are existing IEC materials not being used for counselling?

- What are the opportunity costs of supporting family planning SDPs that are underutilized? Should future resources be allocated to strengthening underutilized SDPs or should support be focussed on improving those that already serve many family planning clients?
- What are the optimum times for scheduling family planning services?
- How should the private sector be best involved in family planning service delivery?
- What is the cost-effectiveness of alternative delivery systems (e.g village health post, CBD, VHW, chemists etc) to the clinic-based model to deliver family planning information and services?
- How efficient is the integration of family planning with other health services?
- What are the perceptions and use by adolescents of family planning services at the SDPs?
- What alternatives to clinic-based FP education could be developed and which are the more effective in bringing potential clients to the clinic?

ii) The following quality of care issues would benefit from further operations research to answer some of the questions raised by the results of the situation analysis study:

- What are the determinants of client/provider relations?
- What are the determinants of method switching and discontinuation?
- What are the determinants of provider bias and what are the effects on contraceptive use patterns?
- What would be the demand for mini-pills if they were readily available?
- What would be the effects of introducing user fees on contraceptive use and on the sustainability of services?
- What would be the effectiveness of increasing and improving clinic-based health talks?

iii) The results presented at the seminar are the preliminary findings from the study and the need for further analyses of the data was identified. More specifically, it was recommended that:

- the data be disaggregated by
 - a) State
 - b) type of SDP
 - c) public / private ownership (including a separation of the PPFN clinics)
 - d) urban / rural location
 - e) volume of clients
- the issue of non-availability of injectables in the clinics be clarified;
- the various determinants of the use of specific methods be examined;

It was also recommended that the situation analysis study should be repeated in three years time to evaluate the impact of interventions being introduced in the immediate future. The future study should again be implemented in the four geographical focus states plus a few other states, including Lagos and Benue States, so that an assessment can be made of the impact of the geographical focus strategy on the availability, functioning and quality of family planning service delivery in Nigeria.

iv) The group agreed that the Operations Research Unit and Network, based at Obafemi Awolowo University, should be responsible for the development and implementation of OR studies to seek answers to these and other operations research questions. However, it was also agreed unanimously that the PHC Division and FHS Project should be responsible for identifying and defining the research issues themselves, and for ensuring that the results of OR studies are disseminated and utilized. Mechanisms for liaison between those identifying the research issues and those undertaking the research should be increased and strengthened.

Appendix 1 Total number of new acceptors, revisits and contraceptives issued by SDPs with complete statistics for the last month in 1992

Family planning services provided	New acceptors	Revisits	Contra-ceptives issued
Total	5,827	10,555	
Combined pill	1,603 n=143	2783 n=14	9310 n=141
Progesterone-only pill	151 n=91	255 n=91	785 n=84
Condom	1,207 n=132	1757 n=129	32,241 n=130
IUD	1,123 n=137	2846 n=134	1682 n=128
Spermicide	1,047 n=127	1047 n=129	7346 n=176
Injection	597 n=136	1800 n=135	2053 n=131
Female sterilization	94 n=91	21 n=87	
Vasectomy	2 n=83	0 n=84	
Norplant	3 n=82	46 n=84	3 n=74
Referrals to another SDP	115 n=107		

NOTE: N = refers to the number of SDPs with available service statistics. The number of SDPs with complete service statistics varied for each method; because of the missing data from many SDPs the figures for each method as well as for the total represent an undercount.

Appendix 2 Percentage distribution of socio-demographic characteristics of family planning and MCH clients

Characteristic	FP clients (n=390)	MCH clients (n=1053)
Age		
< 20 years	1	9
20 - 29 years	40	55
30 - 39 years	45	25
≥40 years	13	5
DK / NA	1	5
mean age (years)	32	30
Marital status		
married / monogamous	68	70
married / polygamous	26	26
never married	2	2
divorced/separated/widowed	4	1
DK / NA	0	1
Parity		
no children	4	12
1-2	18	42
3-4	32	28
5-6	31	12
7-8	10	4
9+	5	1
mean parity	4.3	2.6
Formal education		
none	23	34
primary	34	26
secondary	30	29
post-secondary	13	10
Economic activity		
household activities	9	25
farmer	9	10
trader	53	40
salaried worker	19	13
other	10	11
Religion		
protestant	46	38
catholic	22	18
muslim	31	42
other	2	2

Appendix 3 List of equipment needed for providing clinical family planning services missing from 178 SDPs

TYPE OF EQUIPMENT	PERCENT OF SDPs LACKING
1. Sterilizers	55
2. Angle poise lamps	45
3. Blood pressure gauges	33
4. Scale	30
5. Torch	55
6. Microscope	86
7. Sponge holding forceps	25
8. Artery forceps	29
9. Uterine sounds	24
10. Specula	22
11. Scissors	22
12. Instrument containers	21
13. Swab containers	35
14. Tenacula	35
15. Sterilizing lotion	61
16. Non-disposable gloves	47
17. Disposable gloves	65
18. Kidney dishes	40
19. Stethoscopes	40
20. Stainless steel pails	77
21. Dustbins	49
22. Oblong trays with lids	71
23. Tables	23
24. Chairs	21
25. Examination couch	21

TYPE OF EQUIPMENT	PERCENT OF SDPs LACKING
26. Thermometer	57
27. Needles & syringes	74
28. Minilap kits	93
- Uterine elevator	96
- Tubal hook	97
- Small retractor	97
29. Xylocaine	96
30. Sutures	94
31. Operation theater	89
32. Recovery room	90