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& TECHNICAL ASSISTANCE PROJECT

NIGERIA:
The Family Planning
Situation Analysis
Study

Obafemi Awolowo University

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The Population Council, an international, nonprofit organization established in 1951, undertakes social and health science programs and research relevant to developing countries and conducts biomedical research to develop and improve contraceptive technology. The Council provides advice and technical assistance to governments, international agencies, and non-governmental organizations, and it disseminates information on population issues through publications, conferences, seminars, and workshops.

Supplemental funds, for activities in Benue State, were received from the Overseas Development Administration (United Kingdom).
SUMMARY

Background: A situation analysis study was undertaken to describe the availability, functioning, and quality of health and family planning activities in a representative sample of service delivery points (SDPs) in Nigeria. The results from this study are being used by the Federal Ministry of Health (FMOH), USAID, British ODA and other agencies to plan for improved family planning service delivery in Nigeria.

Methods: Data were collected from 181 SDPs, including hospitals, health centers, and clinics, in six states: Anambra, Benue, Kano, Lagos, Niger, and Osun. The data collection instruments included an inventory of equipment and facilities, staff and client interviews, and observations of client-provider interactions.

Findings: Service delivery is concentrated in a few busy SDPs (19% of SDPs provide services to 75% of all new family planning clients). Accessibility to most SDPs is generally quite good and waiting times are not long. The infrastructure in most SDPs is adequate, although the lack of water and of privacy are problematic at several sites. Basic equipment needed for clinical methods is lacking in many clinics, rendering the services either unavailable or inappropriately provided. Staffing levels are adequate but further training is needed. Most methods are available in at least 80% of the SDPs visited, and supply logistics are only a problem in certain areas. Supervision and record-keeping are generally quite good, although service statistics are poorly kept. A range of methods was discussed with most new clients, but this varied tremendously by state. Counseling for new users tended to include questioning about reproductive and contraceptive preferences, but a lack of IEC materials inhibited the providers' ability to communicate more effectively. Further, information given to clients about methods tended to be superficial. Technical competence during medical procedures could be improved. Most clients were given clear instructions regarding follow-up.

Recommendations: The results have been presented both at the national and state levels. At each seminar, a number of programmatic, policy, and research issues were identified and recommendations for future activities were made.
Contexte de l'étude: Une étude de l'analyse situationnelle a été conduite au Nigéria pour décrire la disponibilité, le fonctionnement, et la qualité des services de la santé et de la planification familiale (PF), en prenant pour échantillon des points de service (PS) représentatifs. Les résultats de cette étude sont en cours d'exploitation par le Ministère de la Santé, l'USAID, l'ODA, et d'autres agences dans le but d'améliorer les services de la PF dans le pays.


Résultats: La plupart des activités sont concentrées dans quelques centres surchargés (19% des PS accueillent 75% des nouvelles clientes de la PF). Les PS sont facilement accessibles. Les visites se font dans des délais raisonnables. L'infrastructure dans la plupart des points de service est adéquate, bien qu'il n'y ait ni eau courante ni de salles privées pour les consultations dans quelques centres. Tous les points de service ne sont pas en mesure de prodiguer correctement toutes les méthodes cliniques, à cause du manque d'équipement de base. Le nombre de personnel est suffisant mais le besoin de formation se fait sentir. La plupart des méthodes sont disponibles dans au moins 80% des centres visités; cependant, certains PS ont des problèmes de rupture de stock. La supervision et le maintien des dossiers sont généralement assez bien suivis, mais le record des statistiques est négligé. Toute la gamme des méthodes est exposée aux nouvelles clientes à un degré varié, selon les différents états. Les conseillères posent des questions aux nouvelles utilisatrices concernant leurs préférences des méthodes contraceptives, mais il leur est difficile de communiquer efficacement en l'absence de matériels éducatifs. En outre, l'information donnée aux clientes a tendance à être superficielle. La technique médicale laisse à désirer. Les instructions du suivi sont claires, dans la plupart des cas.

Recommandations: Les résultats ont été présentés aussi bien sur le plan national que dans les états concernés. Lors de chaque séminaire, un nombre de sujets ayant trait avec le programme, la politique, et la recherche ont été identifiés ainsi que des suggestions faites pour les activités futures.
BACKGROUND

Nigeria is by far the most populous country in Africa, with a total population of 88.5 million in 1991. A population growth rate of 2.7 and a total fertility rate of 6.3 children per woman indicate that these absolute numbers will continue to increase at a very substantial rate. An infant mortality rate of 104 per 1,000 and a maternal mortality rate of 800 per 100,000 further illustrate the serious demographic and health issues facing the Nigerian Government.

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 1960s and 1970s 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. The Government of Nigeria approved a National Population Policy in 1988.
OBJECTIVES

**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.

**Immediate objective:** Over a period of approximately eight months between December 1991 and July 1992, the Operations Research Unit, Obafemi Awolowo University, Ile-Ife coordinated a comprehensive study to describe the quality of care provided to clients and the availability and functioning of 181 SDPs in the public and private sectors.
METHODOLOGY

One approach to undertaking this comprehensive study at the SDP level is to use the "situation analysis" approach. The objective of situation analysis studies 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 policymakers, administrators, and providers of services.

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 and were field-tested in March 1992. Field work was carried out for 30 working days in March and April 1992. A total of six research teams for the national study 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 program 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 Ille-Ife.

The units of analysis for the situation analysis were the service delivery points within the national Primary Health Care program that provide family planning services. Sample SDPs were selected randomly from the total number listed by the FMOH Primary Health Care Division in each of six states drawn from the four health zones of the country. The four "geographical focus" states selected by the Family Health Services Project were used: Anambra, Kano, Niger, and Osun. Lagos State was also sampled because of the amount of family planning activities undertaken there. Because the UK Overseas Development Administration (ODA) was considering focusing its aid in Benue State, this became the sixth state in the sample.

Nigeria is believed to have approximately 1,400 public SDPs that provide family planning services in the country. Using the standard formula for proportions to calculate the appropriate sample size, a minimum of 171 SDPs needed to be sampled to be able to estimate proportions nationally. The total of 181 family planning SDPs therefore represents
a sample of over 10% of SDPs nationwide. A stratification by type of SDP was necessary, because of the wide variety of SDPs that currently provide family planning. A five-category classification was made of hospitals, health centers, MCH clinics, PPFN clinics, and those private hospitals participating in the FHS Project in each state. For Benue State, the SDPs of a missionary organization (NKST) were also included because they are an integral part of the family planning service delivery system.

The numbers of observations and interviews are given in Table 1; they varied considerably by SDP and by state. Because of a lack of family planning clients at some SDPs on the day of the visit, it was possible to observe interactions between clients and providers and to interview clients in only 94 SDPs. Further, 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.

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

<table>
<thead>
<tr>
<th>Sampling Unit</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FP client/provider interactions observed</strong></td>
<td></td>
</tr>
<tr>
<td>new clients</td>
<td>121</td>
</tr>
<tr>
<td>continuing clients</td>
<td>259</td>
</tr>
<tr>
<td>others</td>
<td>15</td>
</tr>
<tr>
<td><strong>Client exit interviews</strong></td>
<td></td>
</tr>
<tr>
<td>new clients</td>
<td>131</td>
</tr>
<tr>
<td>continuing clients</td>
<td>259</td>
</tr>
<tr>
<td>MCH clients</td>
<td>1053</td>
</tr>
<tr>
<td><strong>Staff interviewed</strong></td>
<td></td>
</tr>
<tr>
<td>doctor</td>
<td>2</td>
</tr>
<tr>
<td>nurse-midwife</td>
<td>135</td>
</tr>
<tr>
<td>registered nurse</td>
<td>23</td>
</tr>
<tr>
<td>registered midwife</td>
<td>39</td>
</tr>
<tr>
<td>community midwife</td>
<td>5</td>
</tr>
<tr>
<td>community health officer</td>
<td>32</td>
</tr>
<tr>
<td>community health extension</td>
<td></td>
</tr>
<tr>
<td>worker</td>
<td>33</td>
</tr>
<tr>
<td>nursing aid</td>
<td>12</td>
</tr>
<tr>
<td>other</td>
<td>8</td>
</tr>
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</table>
FINDINGS

Activities at the SDPs

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 (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. 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.

Further confirmation of the differences in the level of family planning activities among SDPs is revealed in Table 2. The distribution of family planning clients shows that while the median number of new clients seen during the last month at an SDP is as low as 11 (that is, approximately one new client every two working days), the maximum number of new clients at one SDP is close to 400 (approximately 20 new clients per day); a similar disparity was observed for the revisit clients and for clients served over the previous year. 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. 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.
Table 2: Summary statistics for new and revisit FP and MCH clients for the last month, with complete statistics in 1992 and for the entire year of 1991

<table>
<thead>
<tr>
<th></th>
<th>For last month</th>
<th>For year of 1991</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>New FP acceptors</td>
<td>FP revisits</td>
</tr>
<tr>
<td>Total (N)</td>
<td>5,827</td>
<td>10,555</td>
</tr>
<tr>
<td>% of SDPs with no clients</td>
<td>3%</td>
<td>7%</td>
</tr>
<tr>
<td>Median (N)</td>
<td>11</td>
<td>25</td>
</tr>
<tr>
<td>Maximum (N)</td>
<td>396</td>
<td>807</td>
</tr>
</tbody>
</table>

As shown in Table 2, most SDPs see many more revisits than new family planning clients; this proportion was also found during this study, where 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% of clients came because they had problems with methods they were using and 7% came to either stop, switch, or seek information on family planning methods.

Accessibility of SDPs

Forty-five percent of the 1,430 family planning and MCH clients went to the SDP on foot. Another 42% of the clients reached the clinic either by a car or bus, and 12% came by other means of transport.

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 fewer 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. 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.

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. 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 opening up to two hours after the official opening time.

**MCH services**
For the most part, family planning service delivery in Nigeria is provided at the same sites as MCH services; only in the eight PPFN clinics sampled is there specialization. Of the 1,053 MCH clients interviewed during the study four main reasons emerged as to why they attended the clinic. Most prominent were antenatal care (30%), child health care (25%), a 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 provided in most SDPs.

**MCH and family planning client profiles**
Although termed "MCH clients," 13% of respondents who had not come for family planning on the day of the visit were currently using family planning; a further 16% were former contraceptive users. Moreover, of these 124 current users, only 77% 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%).

Approval of family planning by these MCH clients was high (87%), although it is higher among

<table>
<thead>
<tr>
<th>Knowledge</th>
<th>Percent of 1,053 clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pill</td>
<td>80</td>
</tr>
<tr>
<td>IUD</td>
<td>67</td>
</tr>
<tr>
<td>Condom</td>
<td>71</td>
</tr>
<tr>
<td>Spermicide</td>
<td>37</td>
</tr>
<tr>
<td>Injectable</td>
<td>74</td>
</tr>
<tr>
<td>Female sterilization</td>
<td>57</td>
</tr>
<tr>
<td>Male sterilization</td>
<td>22</td>
</tr>
<tr>
<td>Norplant*</td>
<td>8</td>
</tr>
<tr>
<td>NFP</td>
<td>30</td>
</tr>
<tr>
<td>Traditional methods</td>
<td>29</td>
</tr>
</tbody>
</table>
current users than among never-users. A similar trend was found when MCH clients were asked their perception of their husband’s approval; among the never-users, a substantial proportion do not know what their husband’s feelings are. This proportion was particularly high in Kano and Niger States.

Knowledge of family planning methods among MCH clients was also high: The proportion who have ever heard of family planning (90% unprompted) is almost double that found in the Nigeria DHS. This finding is not surprising because the situation analysis study is a clinic-based sample and the DHS is a population-based sample. The data in Table 3 suggests that those attending MCH clinics are better informed about family planning than is the general population. Of particular interest is the relatively high proportion (57%) who have heard of female sterilization.

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% mentioned the mass media.

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 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 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 childbearing 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 salaried jobs than the MCH clients. Whereas a lower proportion of the family planning clients overall are Muslim (although this varies greatly by state), that Catholicism does not seem to be a differentiating factor.
Functioning of the SDP sub-systems

**Infrastructure, equipment, and physical facilities**

An inventory was taken at all except three SDPs offering family planning (all in Niger State) to measure existing facilities, equipment and infrastructure. The clinic waiting room and counseling facilities in 178 SDPs were observed. As Figure 2 shows, the majority of the SDPs have waiting rooms or areas that were protected against sun and rain, and most have adequate seating and toilets. Only about three in every five SDPs have auditory and visual privacy for counseling. This lack of privacy may inhibit some clients and staff from participating in a full and honest exchange of information during the counseling 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.

Figure 3 shows features of medical examination facilities observed at each SDP. Visual and auditory privacy are much higher for these facilities, but still about one-quarter of all SDPs do not provide clients with privacy during the medical examination; 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.

As Figure 4 indicates, more than half of the SDPs did not have sterilizers and 61% did not even have sterilizing lotion (not shown). Over half had no lamp or torch, 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.

**SDP staff: experience and training**

Staff interviews were completed in only 87% of SDPs. Of the 23 SDPs where staff were not interviewed, six had no family planning staff at all. For the other 17 SDPs that were supposed to have family planning staff, either the staff were not present on the day of the visit 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 10 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

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**Figure 4: Percent of 178 SDPs missing equipment necessary for clinical FP services**

- Sterilizers: 55%
- BP gauge: 33%
- Examination table: 21%
- Lamp/torch: 54%
- Scales: 30%
is not a strong relationship between the number of family planning staff at an SDP and the number of clients served: In 1991, SDPs with only one provider served 122 new acceptors on average, and those with three providers served 379 new acceptors, on average, yet those with 10 or more staff served 274 new acceptors, on average.

There are various categories of staff working in the SDPs; the most prominent 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. Virtually no doctors are involved in routine family planning service delivery, but they are normally called upon to provide methods that require a greater degree of medical skill.

Twenty percent 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 with five of the six methods (see Figure 5).

Fifty-three percent of staff interviewed said that family planning had been part of their basic health training, which probably reflects the recent inclusion of family planning in their responsibilities; 78% of 289 staff interviewed said they had been providing family planning for five years or fewer. The FMOH is dealing with this problem of undertrained staff through the introduction of the 'Clinical Service Provider' training course. This is the basic family planning update 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.

Apart from basic and upgrade training, a few staff interviewed had received specialist family planning training, most commonly in VSC counseling (11%) and in 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.

**IEC materials and activities**

Figure 6 shows 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. On the day of the research team’s visit, health talks were observed at 56 SDPs, of which 48 included mention of family planning.

Only one-half of the SDPs had a sign indicating that family planning services were available. In the predominantly Muslim 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 contraceptive methods were available at the SDP they were visiting.

Many staff said that they also 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% who did home visits.

Contraceptive supplies and logistics

During each visit to an SDP, 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 (see Figures 7 and 8) show that all methods, except the progesterone-only pill, are widely available; NORPLANT® is still being introduced on a trial basis. Female sterilization is available in 14% of the SDPs visited.

On average, SDP provided 4.5 methods. 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 -- 10% of SDPs do not provide the combined pill, 14% do not provide the condom, and 20% do not provide the IUD or injectable.

While 23% of the SDPs visited were found to stock six or more methods, 16 (9% of SDPs) indicated that they did not provide any methods whatsoever. Yet 12 of these SDPs
had family planning staff in place, suggesting some underutilization of available staff. No clients were observed in these SDPs.

For all methods, more SDPs claimed to provide a method than 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 programs, in the SDPs visited, the discrepancy between those that offered a method and those that stocked the method on the day of the visit was only 3-9%, on average (see Figures 7 and 8).

Figure 9 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, 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.

Among the 181 SDPs, 76% had an inventory of their commodities, 86% had a reordering system, and 73% had adequate storage. Further, 69% of the SDPs stored commodities by date, which implies that over 30% of the SDPs could be storing commodities that have expired without being aware of the fact.

Management and supervision

Although only 70% of SDPs (hospitals and others combined) reported receiving supervisory visits, this proportion is quite good compared with that in other African
countries. Supervision appears 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 visits in the last six months. Sixty-five % of the other SDPs reported 65% having received visits, 23% of them three or more.

In the 124 SDPs that reported having supervisory visits (see Figure 10), the most commonly cited actions were examining records and enquiring about problems; supervisors observed service delivery activities or suggested improvements in less than half the SDPs and in only 15% did the supervisors offer praise to the staff. Although this suggests that supervisors are more inclined to search for faults than to provide positive support, the fact that in 75% of cases they inquired about problems suggests that they do seek feedback from the staff.

**Record keeping and reporting**

Separate record cards were kept for each client in 89% of the SDPs; 85% of the SDPs sent their family planning reports regularly to headquarters, while seven out of every 10 SDPs kept a daily register. The vast majority (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 do follow-up.

Although the records for individual clients were generally quite good, the service statistics for the SDP were in poor condition. Many SDP staff do not know how to keep records and are not interested in doing so; the research teams themselves often had to go through the records and show the staff how to complete the forms.
Of the 178 SDPs, 152 (85%) regularly sent reports to another office; 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 done so within the last two months. While report writing is clearly a high priority, only 37% of the SDPs that send reports receive any feedback on them.

**Quality of care at SDPs**

**Choice of methods**

Even if methods are available at an SDP, they may not be discussed with a client (see Figure 11). While providers discussed the pill and IUD with two-thirds of the clients, the condom and injectable were mentioned during only one-half of the counseling sessions, and spermicides during one-third of the sessions. The pill and IUD may have been emphasized because they were available at the providers' clinics, or the providers simply knew more about them. Female and male sterilization were also mentioned in about one-fifth of the cases, possibly reflecting the fact that providers were "overperforming" due to the presence of the observers.

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 6 or more methods discussed during the counseling session. However, in 12 cases (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 as high as six in Anambra State and as low as two in Niger and Osun States.

**Figure 11: Percent of 163 new and switching clients with whom methods were discussed**

![Figure 11](image-url)
Among providers, the IUD is the preferred option for birth spacing, with the pill as the second favorite method (see Figure 12). Substantial proportions of providers said that their recommendation would depend on the client's condition or her preference.

As Figure 13 shows, the injectable is seen as a long-term method, rather than a spacing method. 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. 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. The client's condition and preferences did not seem to be so important a consideration for women seeking to stop childbearing.

Provider-client information exchange

In assessing whether providers attempt to understand clients' needs, the questions that the providers asked the clients during counseling were observed: Figure 14 describes these observations. Overall, in only one-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.

Of the 121 new clients observed, 55% indicated a preference for a particular method, suggesting that they were already quite aware of family planning before coming to the clinic. 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, 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 themselves 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 with the provider how to manage the problem.

Group health talks and the counseling sessions held with individual clients were assessed. Only 31% of the SDPs visited held a health 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. The daily health talk is often 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.

Unfortunately, IEC materials are rarely used during client counseling. Virtually the only aids used during counseling are contraceptive samples (in 67% of interactions with 163 new and switching clients). Staff occasionally refer to or use a poster on the wall and
sometimes show 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.

Although a number of methods were discussed with most new and switching clients, 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, 86% of them were told how they work, two-thirds were told how to use them, and only about one-half were told about their side-effects, effectiveness and contraindications (see Figure 15). A similar pattern is found for all the other methods.

**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. As Figure 16 shows, 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, four of them revealed abnormalities but they still had an IUD inserted.

During the 40 pelvic examinations observed, 68% of the clients were informed by the provider what 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 solution, 48% lacked nondisposable gloves, and 65% lacked disposable gloves.

It is usually considered necessary to check the blood pressure of clients contemplating hormonal methods; however, for over one-third of new hormonal method acceptors and virtually all resupply users (94%), blood pressure was not taken. For lactating clients, particularly those under 12 months postpartum, hormonal methods—especially combined pills—are not generally recommended. Figure 17 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. In the exit interview, it was determined that 23% of all clients were breastfeeding. The figure indicates that 28% of combined-pill users (both new and continuing) were currently breastfeeding. More thorough questioning of clients during the counseling 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.

Figure 17: Percent of family planning clients asked about their breastfeeding behavior
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. Virtually all clients (97%) were observed to be given a friendly greeting by providers, but only one-third were asked at the end of the session whether they had any questions.

As can be seen in Figure 18, 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 were less likely than others to have to wait for more than 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.

Client satisfaction

The satisfaction of the clients is ostensibly a function of the quality of service provided. However, client satisfaction is difficult both to conceptualize and to measure. For this study, each client was asked to rate the service they had received in terms of a number of items (see Figure 19).
It is somewhat hard to believe that level of overall client satisfaction is as high as this figure indicates, given that the quality of service received was so variable. Possible explanations 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 counseling session, only 54% obtained the method they had indicated. Furthermore, during the exit interviews, 23% of clients said that they would have preferred another method. The IUD was the most frequently provided method given 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.
RECOMMENDATIONS

Preliminary study results presented at the national seminar held July 30, 1992 led to a series of recommendations for policy and program development and for further operations research being made. These included:

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 19 further action points were made for these and other sub-systems.

Recommendations for improving quality of care

- A number of factors were identified that may inhibit the choice of family planning services available to a client at the SDPs. Recommended actions to address these issues included improving staff counseling training, creating awareness among policymakers of the potential for community mobilization, and training all health personnel in family planning.

- The study showed that clients did not always receive adequate and appropriate information about the methods available. To improve this situation, it was recommended that the delivery of family planning information be improved by various means.

- The technical procedures followed by service providers for medical and pelvic examination were not always sufficient. Consequently, it was recommended that refresher training be provided regularly for all family planning providers, SDPs be adequately equipped, and management and supervision of staff be strengthened through training.
The average waiting time was found to be satisfactory overall, although it was recommended that action be taken where waiting time is long.

**Recommendations for policy development and funding requirements**

The overall focus for implementation of the national population program should be maintained. However, different strategies should be considered based on locally prevalent circumstances. Seven additional broad policy recommendations were identified relating to:

- Training of health professionals
- Clarifying administrative relations between state and local governments
- Strengthening activities at the community level
- Integrating family planning messages into PHC communication strategies
- Increasing the number of trained female providers
- Improving financial management at the clinics
- Focusing donor assistance.

**Further operations research for service delivery problems**

A situation analysis is a diagnostic tool that highlights service delivery problems that can be addressed by further operations research activities. During this seminar, 12 service delivery problems were identified that could benefit from operations research. In addition, six quality of care issues were identified for which operations research could provide greater insight.

The results presented at the national seminar were the preliminary findings from the study and the need for further analyses of the data was identified. More specifically, it was recommended that the issue of nonavailability of injectables in the clinics be clarified, the various determinants of the use of specific methods be examined, and the data be disaggregated by:

- Type of SDP
- Public/private ownership (including a separation of the PPFN clinics)
- Urban/rural location
- Volume of clients.
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, 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.

Seminar participants 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, and that the PHC Division and FHS Project should be responsible for identifying and defining research issues, and for ensuring that the results of OR studies are disseminated and utilized.
PROGRAM IMPLICATIONS

The process of disseminating the results of the study and ensuring that they could be utilized by program managers included four major elements:

1. **Involvement** by the relevant program administrators and researchers in a three day **planning workshop** that 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** attended by the same participants as the planning workshop. Data were 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 were prepared following this workshop.

3. **A one-day national dissemination seminar** to present results to national-level policy makers and managers. The draft version of this report formed the basis of this seminar.

4. **Three one-day zonal dissemination seminars** were held to present the state level results to managers at the zonal, state, and local levels. These presentations were based on the state reports; the objective was 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.

The results presented above have also been disaggregated by state, and individual reports for the six states are available from The Population Council.