

# Family Planning Situation Analysis in Ethiopia

## Objective

To assess the readiness of Ethiopia's health system to expand family planning service delivery in select sites, particularly long-acting and permanent methods (LAPMs).

## Methods

This cross-sectional study was designed and implemented using the Situation Analysis methodology, which included collecting data through provider interviews, facility inventories, service delivery observation, and exit interviews with family planning (FP) clients. One hospital (if available), two health centers, and two health posts per *woreda*\* were included in the study. Data were collected over a four-week period in 2011 by a field team that included nurses, health officers, and public health professionals.

\* *Woreda* or districts are the third-level administrative divisions of Ethiopia and are managed by a local government.

## Findings

- The FP providers were mostly female. They were nurses or health officers at hospitals or health centers, and health extension workers (HEWs) at health posts.
- A significant number of HEWs perceived that they had a high workload; however, further research is needed to verify this perception.
- Clients who presented for services reported that facilities with FP services were close by and had convenient hours of operation. Most FP clients reported receiving services at no cost. Re-supply was the main reason for visits; new users were approximately one-fifth (22%) of hospital and health center clients, and one in ten (11%) at health posts.
- Overall service delivery appeared to be good, and range and availability of FP methods, particularly in hospitals and health centers, was high. The majority had more than four method choices available. Facilities were generally well stocked, but occasional stock outs were reported.
- Providers of all levels reported interest in receiving training for providing the intrauterine contraceptive device (IUCD) and implants; however, there was also evidence of provider misperceptions about these methods that need to be addressed during training.
- Generally the service environment and infrastructure were good; however, basic infrastructure was limited in health posts, including water availability and hand washing bowls. Over 70% of the hospitals and health centers had the necessary equipment to deliver a wide variety of FP services. This indicates that with training and an adequate supply of consumables, the providers have a greater capacity to increase the variety and provision of long-acting FP services.
- Half of the providers surveyed at hospitals and health centers were trained in IUCD insertion and removal, and 60% were trained in implant insertion and removal. Providers at health posts are exclusively providing short-acting methods and

insertion of the implant Implanon, which is consistent with the recommendations in the FP guidelines for Ethiopia. However, 65% of the HEWs had not received training in Implanon insertion; a majority of the HEWs cited this lack of training as the reason they did not provide Implanon insertion.

- Client awareness of long-acting methods is very low. For example, only one-third of women knew about IUCDs. Client counseling also needs to be improved, especially related to side effects and problems encountered.
- Regarding oral contraceptive pills, most providers prescribed one to four cycles per visit. However, evidence indicates that dispensing 13 cycles during the initial visit is more effective,<sup>1</sup> and the 2010 Policy Guidelines for Family Planning Services recommends dispensing 13 cycles.

## Conclusions

The situation analysis found that most health facilities have the capacity to provide short-acting methods, and that the basic infrastructure for IUCD and implant insertion exists. Provider interest in these longer term methods also exists, although training for new and existing providers is necessary to expand coverage. While this study was not intended to generate conclusive evidence of the impact of the FP interventions of the government, there is suggestive evidence that government efforts to improve FP access have been successful. For example, services are near many clients and operating hours are convenient. This study identified some possible barriers to an uptake in long-acting methods, such as low awareness (especially of IUCDs) and provider misperceptions about restrictions related to age, parity, marital status, menstruation, and the need for husbands' consent. In Ethiopia, FP guidelines do not address these possible restrictions and need to be revised. Overall, the analysis shows that the Health Extension Program has greatly improved access to FP services and has the capacity to continue to expand FP use, particularly for long-acting and permanent methods.

## Background

To respond to the low utilization of preventative health services in Ethiopia, the Federal Ministry of Health (FMOH) launched the Health Extension Program in 2003 with a strong emphasis on rural health care services. In a novel approach to task-sharing, this program included the development of rural health extension workers (HEW) as a new cadre of government-employed health worker stationed at health posts. The HEWs provide an opportunity to expand FP services to rural areas in Ethiopia. In 2009, the FMOH launched a program to train HEWs to insert Implanon, a single rod contraceptive implant, at health posts as a means to expand the method mix, which had previously been composed largely of short-acting methods. The FMOH intends to train one HEW per health post to insert Implanon for a total of 15,000 Implanon-trained HEWs. With the expansion of the Implanon initiative in 2010, the FMOH also launched a revitalization program for the IUCD, initially in 94 woredas from six regions of Ethiopia. The expansion of the method mix to include long-acting methods will help the Government of Ethiopia (GoE) to meet the Millennium Development Goals (MDGs). The GoE has set a

*The objective of this study was to assess the readiness of the health system to expand FP service delivery in the selected sites, particularly long-acting and permanent methods (LAPMs), through the Health Extension Program.*

target to achieve a total fertility rate (TFR) of 4 and a contraceptive prevalence rate (CPR) of 65% by 2015.

While commitment is strong, meeting the MDGs will be a challenge for Ethiopia, which has a population of 77 million.<sup>2</sup> Fertility is still high in Ethiopia with a TFR of 4.8 (urban TFR of 2.6, rural TFR of 5.5). The CPR for any method (modern and traditional) among currently married women in Ethiopia aged 15-49 increased from 15% in 2005 to 29% in 2011; and the CPR for modern methods increased from 13.9% in 2005 to 27.3% in 2011. Much of

the increase in CPR is thought to be due to the Health Extension Program.<sup>3</sup>

## Study Objective and Design

The objective of this cross-sectional study was to assess the readiness of the health system to expand FP service delivery in the selected sites, particularly for LAPMs. The study was designed and implemented using the Situation Analysis methodology, which includes collecting data through provider interviews, facility inventories, service delivery observation, and exit interviews with FP clients.

Only health facilities in the 94 woredas chosen initially by the FMOH for the IUCD revitalization were eligible for selection into the study sample. From these 94 woredas, the sample was stratified by region, and a random sample of 30 woredas was selected proportional to the number of eligible woredas in each region. Within the selected woredas, a purposive sample of health facilities was selected based on accessibility. The study aimed to select one hospital (if available), two health centers, and two health posts per woreda for inclusion in the study.

At each facility, up to three staff who routinely provide FP services and were on duty at the time of the visit were eligible for inclusion in the provider study sample. Data collectors observed interactions between providers and clients. They also recruited observation clients for the study as they arrived at the Maternal and Child Health/FP unit; they obtained consent from both the providers and the clients to observe their interaction. All clients between ages 15 and 49 who were there on the day of the data collection were eligible for an exit interview. The study team intercepted and interviewed clients after they received FP services, with the target of interviewing up to six new and six return clients; however, due to the low number of clients, virtually all FP clients who received services during the survey date were selected and interviewed. The team attempted to interview the same clients who were observed during the provider-client interaction; however, not all observed clients consented to being interviewed.

**Data collection.** Data collection took place over a four-week period from May to June 2011. Data were collected by nine teams with three data collectors per team (two male and one female), and a supervisor was assigned to each team. All data collectors

had medical or public health training and mostly consisted of nurses, health officers, and public health professionals. Prior to deployment to the field, they received one week of training on research ethics, the data collection tools, and study procedures. The teams of data collectors deployed simultaneously to geographically clustered woredas to facilitate easier access and limit lengthy travel to sites. Each team was assigned three to four woredas, and in each woreda they collected data in one facility each day. While at the facility, a female data collector observed providers delivering FP services, while the two male data collectors conducted the facility inventory and the provider and client exit interviews.

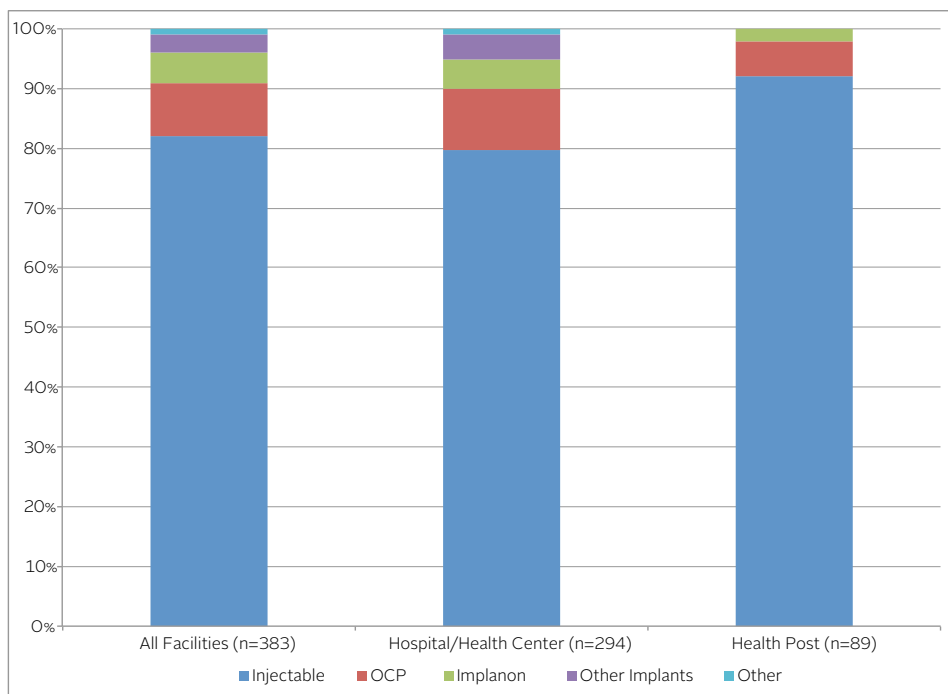
**Study limitations.** The main limitations are below.

- The Situation Analysis methodology is designed to provide a snapshot of FP services on a single day at each facility. Because a facility is only visited for one day, the number of clients receiving less popular methods is limited. In this instance, the vast majority of clients received DMPA injections, and very few clients were observed receiving implant or IUCD insertions.
- The study focused only on women who came for FP services, thus the FP practices or intentions of women who came for non-FP services were not captured. Also, HEWs, while based at health posts, spend a significant portion of their time doing community-based service delivery and, as a result, many of the non-clinic based clients of HEWs were likely not represented in the sample.
- The generalizability of the findings is limited given that the data are based on a convenience sample. For example, in each woreda, only easily accessible facilities were surveyed, so FP service provision and circumstances of the facilities in remote and difficult to reach areas may not be represented by these findings.
- The woredas selected for inclusion in the study could be performing differently than other woredas due to their inclusion in the IUCD scale-up initiative.

## Results

**Sample characteristics.** Almost all FP service providers at the hospitals and health centers (98%) were nurses or health officers, while at the health posts, 98% were trained as HEWs. The FP providers were

### Percent distribution of clients who received each FP method, by facility type\*



\* In the situation analysis methodology used, the facilities were visited for one day, so the number of clients receiving less popular methods is limited.

mostly female, with an average age of 28.3 years in hospitals and health centers, and 23.2 at the health posts. The FP clients were mostly married, Ethiopian Orthodox religion, and the majority, especially in health posts, had no formal education.

**Personnel, infrastructure, equipment, and operations.** In hospitals and health centers, nearly half of the providers had received training in IUCD insertion, and 52% had received training in IUCD removal. Additionally, nearly 60% had received training in implant insertion and removal. In comparison, 37% of the HEWs had received training in Implanon insertion—the only implant authorized for insertion at health post level. No HEWs are being trained in Implanon removal or IUCD insertion or removal. The overall FP service delivery environment (medical examination areas, cleanliness, lighting, and privacy) was good; however some basic infrastructure for FP services, such as running water and hand washing bowls were limited in many health facilities. Most hospitals and health centers had the necessary equipment for delivering long-acting FP methods. FP services were provided five days in a week in most health facilities, and the majority of FP clients considered facility operating hours to be convenient. A large percent of the HEWs perceived having a high workload (62%), compared with the hospitals and health center providers (33%).

**Reasons for client visit and availability of FP services.** The main reason for visiting the health facility for most of the FP clients was to obtain a re-supply of their FP method. New FP users constituted around one-fifth (22%) of the hospital and health-center clients and made up 11% of the clients in health posts. Most health facilities reported providing a range of short-acting methods, with injectables being the most available and most dispensed method. Hospitals and health centers had on average more than four different FP methods available at the time of the survey. Of the long-acting methods, Implanon was relatively more available than the other long-acting methods.

**Supplies and logistics management.** Most of the facilities that reported usually providing a particular FP method were found to also have it in stock at the time of the survey, but some facilities also reported experiencing stock-outs in the past six months. In the facilities that usually provided IUCDs, 93% had it in stock at the time of the survey. Of the facilities that usually provided Implanon, it was generally found to be in stock at the time of the survey. Overall, more than 90% of all facilities had injectables and oral contraceptive pills (OCPs) in stock. Facility observations showed that most of the hospitals and health centers had better organized record card systems than the

health posts (82% compared to 57%). Written inventories for FP methods were, however, lacking in a number of health facilities.

**Quality of care.** Most FP clients reported receiving services at no cost. For hospital and health center clients, providers (52%) tended to dispense three to four cycles of pills at each client visit for clients who had been on OCPs for at least one year. Comparatively, the majority of the HEWs tended to dispense only one or two cycles at each visit. Evidence shows that dispensing 13 cycles during the initial visit is more effective, and the 2010 Policy Guidelines for Family Planning Services recommends dispensing 13 cycles.

Most providers who had conducted IUCD and implant insertions reported that they were comfortable with conducting insertions. For those who had not conducted any insertions, a lack of training was cited as the primary reason. However, the majority of providers (including those who had never been trained in IUCD and implant services) were interested in providing IUCDs and implants.

Generally, most of the providers reported several factors affecting their decision to

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provide FP methods. These factors included: minimum and maximum age, marital status, partner consent, and menstrual status. For example, providers gave different ages as the minimum and maximum ages they used to determine eligibility for a method. The mean minimum age nurses and health officers reported for prescribing OCPs was 15.4 years, and HEWs reported it as 15.9. The mean maximum age for prescribing OCPs was 44.2, reported by nurses and health officers, and was 42.8 years, reported by HEWs. For implants, there was an even greater difference between the ages recommended by

nurses and health officers versus HEWs. Nurses and health officers reported the minimum mean age as 16.6 but HEWs reported it as 18.6. The majority of providers were open to dispensing FP methods to non-married clients, with the exception of sterilization. One difference was that 76% of nurses and health officers were open to inserting implants for unmarried women, but only about half of the HEWs were.

In 71% of the service delivery observations, hospital and health center providers obtained demographic information from the clients. This was higher than in health posts where client's demographic information was collected from only 44% of the clients. Similarly, in the service delivery observations conducted in hospitals and health centers, providers were more likely to ask about their clients' reproductive goals, compared with health post providers. During counseling, 95% of providers at hospitals and health centers asked clients what their FP method preference was, compared with 83% of the providers at health posts. The majority of the clients in hospitals, health centers, and health posts indicated a method of preference.

## Conclusions

Based on these findings, most of the health facilities surveyed have the capacity to provide short-acting methods. They also have the basic infrastructure and provider interest in offering long-acting methods, such as IUCD and implant insertion. However, training of existing and new providers is necessary to expand coverage. The findings also show that the

government strategies to improve access to FP services are succeeding, given that clients receiving services in the study sites are able to access facilities less than an hour walk away, and operating hours are convenient to clients. The major infrastructure need is to increase the availability of water in the FP/MCH units.

This study also established that possible barriers to long-acting methods uptake include low awareness, particularly of IUCDs, and provider perceptions of restrictions related to client's age, parity, marital status, menstruation, and husbands' consent. Current FP guidelines do not discuss these possible limitations and how they can be addressed, which indicates a need to review and supplement the guidelines. Furthermore, HEWs perceive their workload to be heavy. Because this study was not designed to sufficiently measure workload adequately, further investigation may be necessary on this question, including what exactly may be causing the perceived heavy work burden on HEWs.

Overall, the results show that the FP interventions of the FMOH, including the Health Extension Program have significantly improved access to FP services. Training lower-level cadres of providers such as HEWs to provide FP services appears to have been successful. With the continued commitment and support of the Government of Ethiopia, access to FP services, including longer-term methods, can be further expanded, and Ethiopia will serve as a model for other countries.

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3. All other information in this paragraph is from: Central Statistics Authority of Ethiopia and ORC Macro. *Ethiopia Demographic and Health Survey 2011*. Addis Ababa, Ethiopia and Calverton, Maryland, USA: Central Statistics Authority and ORC Macro, 2011

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