Original article

Situation analysis of family planning services in Ethiopia

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Abstract: This study was conducted to examine family planning service delivery of the health institutions of the Ministry of Health with respect to the facilities needed to provide services and measure the quality of care. Data for the study have come from randomly selected 152 health institutions drawn from some regions of the country. Results of the study have indicated that there are shortages of trained personnel in family planning and contraceptive supplies, and inadequate supervision of the health institutions. It has further been observed that most of the health facilities lacked adequate space for waiting rooms and some of the blood pressure apparatus and weighing scales were non-functional. Despite these difficulties, the quality of family planning service provided seems to be adequate, at least, from the client's perspective at hospital and health center levels. However, the limited choice of methods available in the health institutions, insufficient information given to the clients about the available family planning methods, the possible side effects and their management, the lack of privacy during counselling and examination as well as the absence of follow-up mechanisms and, in general, providers bias towards other health services are of great concern. Health institutions need to be equipped with the necessary materials and human resources, and priority attention should be given to the identified weaknesses. [*Ethiop. J. Health Dev.* 1998;12(2):95-102]

Introduction

Ever since the World Population Conference in Bucharest in 1974, and, even earlier, since the inception of public sector involvement in the provision of contraceptive services, the idea of integrating family planning and health activities has occupied a pivotal role in the field of population (1).

In integrating family planning programs into other health components and/or development activities, emphasis should be given to ideas that would be acceptable by the community. In some countries integrating family planning with other health services has shown good results; in other cases to integrate it with other development components, such as social services, education and economic planning may be necessary.

In the Ethiopian context, family planning services are integrated with Maternal and Child Health (MCH) programs of the Ministry of Health (MOH). Although the Family Guidance Association of Ethiopia (FGAE) has stressed and supported the integration of family planning with other health programs from its inception in 1966, it was in 1970 that the idea got realized. Since then the Association has made concerted efforts to strengthen the integration activity by providing technical assistance and commodity supports to government owned and other health institutions. This effort was also enhanced when FGAE initiated a training program for health workers, mainly for nurses and health assistants, in the theoretical as well as practical concepts of family planning in 1975.

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This endeavor was further intensified by the 1980 directives of the Council of Ministers of the Government of Ethiopia concerning the integration of family planning services with the maternal and child health programs.

The quality of routine family planning programs that daily serve millions of women worldwide and that may have significant impact on safe and informed contraceptive use and reproductive health, has become the focus of donor and government attentions only in the last few years (2). It is frequently stated in the literature that improving quality of care serves individuals better and indirectly decreases fertility by increasing acceptance, continuation and prevalence of contraception (3) In the past few years, there has been increased concern about the quality of services provided by family planning programs and scholars stated that improving the quality of care will lead to higher contraceptive acceptance and prevalence rate, higher continuation rates and, ultimately, lower fertility (4). Quality of care in family planning programs has recently been measured by six fundamental elements developed by Judith Bruce in 1990: choice of methods, information exchange, provider-client relations, mechanisms to encourage continuity, provider technical competence, and appropriate constellation of services (5).

The analysis, therefore, attempted to examine the family planning service delivery endeavors of the health institutions of the MOH with respect to the facilities needed to render the services and to measure the quality of care. It has also tried to highlight the strengths and weaknesses of family planning service delivery of the health institutions and to suggest areas that should be improved. The specific objectives of the analysis were:-

1. to assess the family planning services of the health institutions with regard to IEC programs, logistics and supplies, supervision, the Management Information System (MIS), as well as staffing pattern and training;
2. to assess some of the elements of the quality of FP services of the selected health institutions as perceived by clients and through observations; and
3. to identify constraints of service delivery and to make recommendations.

Method

Government owned health institutions that provide family planning services were used as the unit of analysis for the study. Hence, data for the analysis have come from randomly selected government health institutions. In 1993, there were a total of 1521 (6) health institutions in the country that provide family planning services in addition to their routine health (MCH) programs. A total sample size of 152 health institutions (10% of the total health institutions) was set and a stratified random sampling scheme was employed to select the study health institutions. Regions were stratified into seven, following the FGAE's regional structure. Probability proportionate to size (PPS) scheme was employed to select samples from each region, proportion being the reported number of health institutions that provide family planning services in each region.

Using the sampling frame (lists of health institutions offering family planning services) sample service delivery points were randomly selected and were visited by teams consisting of senior nurses, regional FGAE managers, and the principal investigator. About 45 to 60 minutes were spent in each health institution.

For the purpose of this study three sets of data collection instruments were designed, pretested, and utilized. These were an observation form with an inventory of facilities, equipments, supplies, records, program components, and client-provider relations; a questionnaire to interview service providers and structured questionnaire for clients exit interview. Some of the elements of quality of care were assessed using the information generated from clients exit interview. Observations were also made by senior nurses of FGAE and the principal investigator in the course of data collection. Enumerators recruited from the corresponding selected areas were responsible to carry out the exit interviews.

A total of 286 new and revisit family planning clients who were attending the service delivery points to seek the service at the time of visit were interviewed. Of the total clients, 83.6 percent were

drawn from the busiest service delivery points (hospitals and health centers). In most of the clinics visited, there were no clients for services on the day of visit. In addition, 300 service providers (nurses and health assistants), an average of two from each health institution, were interviewed. The study was carried out between August 1994 and January 1995.

Results

The analysis revealed that regular family planning talks as part of general health education were held in the visited health institutions, in most cases in the hospitals and health centers. However, on the day of visit only few health institutions featured FP talks. Availability of educational materials in the health institutions was found to be poor, although posters were displayed on walls of about 57% of the health institutions (mainly in the hospitals) and leaflets were available in only three health institutions. No educational materials were seen in about one-fifth of the visited service delivery points (Table 1).

Table 1: **Percentage distribution of health institutions by availablity of IEC material**

IEC materials	Health Institution			
	Clinic	H. Center	Hospital	Total
None	30.4 (28)	10.0 (4)	-	21.1 (32
Elip Chart	26.1 (24)	60.0 (24)	45.3 (9)	37.5 (57)
Poster	51.1 (47)	60.0 (24)	80.0 (16)	57.2 (87)
Teaching Aid	16.3 (15)	17.9 (7)	25.0 (5)	17.8 (27)
Leaflets	1.1 (1)	2.5 (1)	5.0 (1)	2.0 (3)

N.B Figures in Parenthesis are Number of Cases

Eight different methods of contraception were made available during the visits of the health institutions. About 97% of the service delivery points were providing pills, 87.5% distributing condom, and 39.5% were inserting IUCD. Less than half of the visited health institutions were offering injectables and Neo-sampon and few hospitals in Addis Ababa were providing Norplant and VSC services (Figure 1). The mean number of available contraceptive methods ranges from about five in the hospitals to about two in the clinics.

At the time of the visit, a little more than one half of the health institutions were found with two or more months supply of pills (53.6%), while it was 53.1% for condoms, 59.6% for IUCD and 35.4% for injectables (Figure 2). About seven percent of the health institutions had run out of pills, IUCD and condoms, while it was 12.5% for injectables.

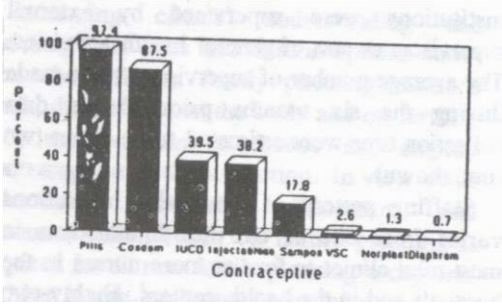

Figure 1: **Percentage of health institutions with FP supplies by method**

Client registration books, mostly hand drawn notebooks, were available in the visited health institutions to register new family planning clients. Accordingly, various client record cards were available in the service delivery points. However, the required information in the case record cards were completed in only 55.3% of the health institutions. The cards were completed better in the health centers than in the hospitals and clinics and were properly arranged for quick retrieval in 81.6% of the health institutions (Table 2).

With regard to supervision, it was indicated by 67% of the interviewed service providers that family planning activities of the health

Table 2: **Percentage distribution of health institutions by ecord handling.**

Health Institution	Records **r** completed properly	organized properly
Clinic	51.1 (47)	79.3 (73)
Health Center	62.6 (25)	90.0 (36)
Hospital	60.0 (12)	75.0 (15)
Total	55.3 (84)	81.6 (124)

N.B Figures in parenthesis are numbers of cases

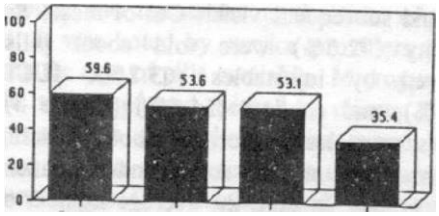

Figure 2: **Percentage of health institutions with two or more months supply in stock**

institutions were supervised by external supervisors as part of general health activities. The average number of supervisory visits made during the six months prior to the data collection time were estimated to be about two (not shown).

Staffing pattern of the health institutions varies from one or two health assistants in most rural clinics to four or more nurses in the hospitals and in the health centers. Eighty-two percent of the health institutions have a person assigned for the coordination of MCH/FP services and 70.2% of them have skilled personnel available at all times of the family planning service hours. These skilled personnel, however, were well stationed in only 28.3% of the health institutions, mostly in the hospitals (Table 3).

Table 3: **Distribution of health instituions by available skilled personnel**

Health for the coordination personnel	someone assigned personnel	skilled Available	skilled well stationed
Clinic	80.4 (74)	64.8 (59)	16.3 (15)
Health Center	82.5 (33)	77.5 (31)	40.0 (16
Hospital	90.0 (18)	80.0 (16	60.0 (12)
Total	82.2 (125)	69.7 (106)	28.3 (43)

N.B Figures in parenthesis are number of cases.

Of the total interviewed staff, about two-thirds have received formal family planning training and most were found in the hospitals. Among them, only one-third have attended refresher courses (not shown).

The quality of family planning services of the health institutions was assessed from the clients perspective as well as through observations. In this regard, about 89% of the interviewed clients claimed to be informed about family planning methods at the time of first and subsequent visits. Out of these, the majority (92.5%) were told about pills, followed by injectables (63.2%), IUCD (56.5%), and condom (54.6%) (Figure 3). Clients were least informed about foaming tablets as well as long acting and permanent contraception. In sum, the average number of contraceptive methods discussed was estimated to be 2.4.

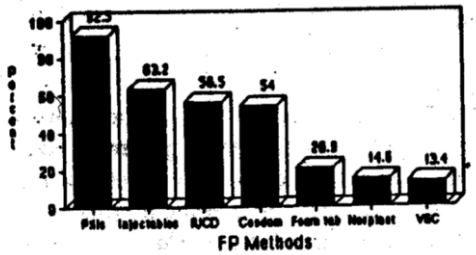

Figure 3: **Percentage of Clients informed about each FP method**

In view of the relevance of good quality information for adopting contraception and increase continuation rate, clients who took part in the exit interview were asked whether the service providers explained how each method works, and how to use them, the possible side effects, and what to do if problems arose in connection with method use.The overwhelming majority (97.2%) of the clients claimed that they were told about how to use the methods and 90.9% were informed about the possible side effects and contraindications of each method. Consequently, 89.1% of the clients were told about what to do if problem arose related to method use and 82.1% were informed about how the methods work (Figure 4). Through observations, however, about 80%, 45%, and 42% respectively were told how to use the methods, about side effects and what to do if problems arose.

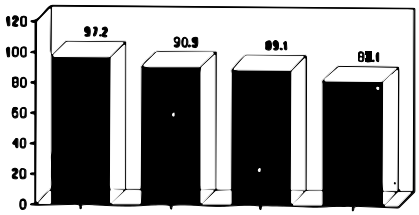

Figure 4: **Percentage of clients provided with information about the methods**

With regard to provider-client relations, almost all the interviewed clients noted that service providers were friendly with them. Although complete privacy was not observed in most health institutions, about 96% of the clients claimed to be satisfied with the overall services of the service delivery points (not shown). Through observation, however, provider-client interactions were found skimpy. Providers have not given adequate time to counsel the clients and provide the services.

Mechanisms to ensure continuity seem to be established in the visited service delivery points. All but two of the clients receiving family planning services at the time of visit were advised to return for resupply and were scheduled for next appointments. In few health institutions it was observed that clients have an identification card at the back of which date of next visit is registered.

Discussion

Family planning services are provided to the needy during working days and hours throughout the week (Monday to Friday). At the time of visit, all but two health institutions (clinics) were found providing family planning services. However, in most of the clinics, clients were not available at the time of visit. The two clinics mentioned were not offering the services at the time of visit due to shortage of contraception.

Almost all the visited clinics have only one room for the general health services and separate rooms for MCH/FP services were observed in the hospitals and the health centers. Interestingly, however, most hospitals and health centers were lacking waiting rooms, although they are busy in offering the services.

Relatively, hospitals and health centers seem to have more basic equipments for the provision of family planning services than the clinics. In all the visited clinics, although blood pressure gauges and weighing scales were physically available, they were not functional in some of the clinics. It was observed that a little less than half of the visited health institutions have adequate equipments and almost all rural clinics were lacking water supply. The facilities and equipments of the service delivery points are inadequate compared with other countries, such as Tanzania, Nigeria, and Senegal (7,8,9).

Increasing clients' understanding and reducing their fears and misconceptions about how the different family planning methods work, their effects on the body and on fertility (10) enable them to choose and employ contraception with satisfaction. In view of its relevance, Information, Education, and Communication (IEC) on family planning is required for all new family planning acceptors.

Most health institutions scheduled and held family planning talks at least once in a week and some have this program once in two weeks time. More regular family planning talks seem to be held in the hospitals and health centers than in the clinics. In some clinics family planning IEC is virtually non-existent. This could partly be attributed to lack of staff who are able to give FP talks. IEC activities in the service delivery points are also weak in other countries (9).

The average number of available family planning methods ranges from about five methods in the hospitals to about two methods (mostly pills and condom) in the clinics. In sum, an average of about three methods were available in all the visited health institutions. This indicated that method mix seem to be inadequate in the health institutions in general and in the clinics in particular. Thus, a concerted effort should be exerted to improve the method mix of the health institutions so that clients could have a wider choice of contraception. On average, the number of methods provided per service delivery point in Nigeria was 4.5 (8).

A two or more months supply of stock of pills, condom and IUCD was found in a little more than one-half of the health institutions, whereas few health institutions run out of pills, condoms, and injectables at the time of the visit. It was noted by service providers that among the type of pills available, Microgynon is the most preferred method by clients. The observed high demand for Microgynon has created shortage of the method in most service delivery points. On the other hand, it is worth mentioning that due to low use of condom and IUCD, a relatively good supply of the methods was observed in stock.

A properly organized management information system (MIS) is a useful tool for program planning, monitoring, and evaluation. In this regard, service statistics are recorded and monthly performance reports are sent to the next health service level, although different reporting formats were in use. Problems of defining and reporting “repeat” and “continuing” acceptors was also observed. Furthermore, it was found out that the data collected from the service delivery points are not analyzed and there is no system of feedback from higher to lower health institutions, resulting in weak management information system. Thus, all the recording formats being used by the service delivery points need standardization and the information needed to be analyzed and used for evaluation and planning purposes.

Although frequent supervision is vital for service improvement, all the staff interviewed said that no specific supervision was made on family planning per se but, as part of other health programs. External supervisors were at the health institutions for supervisory visits to observe the family planning activities, discuss problems related to the services, and provide suggestion for the observed problems. The interviewed staff rated the frequency of supervisory visits that were made by the external supervisors as inadequate.

With regard to training of staff in family planning, relatively more trained personnel were available in the hospitals than in the health centers and in the clinics. Some of the health institutions were also found offering family planning services (including IUCD insertion and injectables) with untrained nurses and health assistants. This generally showed that there is a need for, and expansion of, basic family planning training to reach most staff of the health institutions.

Besides, there is a high turnover of trained staff due to transfers, promotion or release from the services. Trained staff should be provided with some forms of incentives to stay longer in the health institutions. In addition, when a trained person is transferred or when he/she leaves the health institution a replacement should be considered immediately. Of course this will be possible only if there are enough health workers trained in family planning.

The Quality of family planning services of the health institutions was assessed based on the data obtained from the clients' exit interviews and observations.

With an average of 2.8 methods available in the health institutions, the average number of contraceptive methods discussed was 2.4. This clearly showed that clients were mostly informed only about the methods that are available in the service delivery points. The limited available methods in the health institutions is a constraint on the choice of the methods.

In the absence of correct information, it is not surprising to observe fears and misconceptions about the methods which may prevent people from using them or from using them effectively (10). Subsequently, if the contraceptive methods are not explained sufficiently and side effects appreciated, users are much more likely to discontinue using them.

Clients claimed to be well informed and counselled about how to use the methods and about the possible side effects. Practically, however, side effects and contra-indications of each of the methods were not explained sufficiently. This is an area that requires strengthening to attract users and avoid dropouts related to fear of side effects. Thus, service providers need to provide adequate information about all the methods with equal vigor, though not available in the health institution.

Clients' interactions with service providers could be attributed to the clients overall satisfaction with the services. However, on the interaction observed, clients have not been given enough time and were more likely to be asked by the providers about problems they were experiencing with the method they were using and other related issues. Rather they give priority to other health services than family planning. It was also observed that clients do not have complete privacy during counselling and examination.

Accordingly, a service of good quality should enable a client to achieve her reproductive intentions rather than emphasizing acceptance of a particular contraceptive method. A service provider should encourage sustained use of family planning services for women seeking to space or limit births (11). To ensure continuity, the service providers should tell the clients when to come for resupply. All but two of the clients who received family planning services at the time of visit were advised to return for resupply, and 98.9% were scheduled for next appointments. However, followup mechanism was virtually non-existent in almost all the visited health institutions. Therefore, a mechanism has to be established by the service delivery points to follow up the clients who miss their appointments.

In conclusion, the study has indicated shortage of trained personnel in family planning, shortage of contraceptive supplies, and inadequate supervision of the health institutions. It has further been observed that most of the health facilities lacked adequate space for waiting rooms and some of the blood pressure apparatus and weighing scales were not functional. In all the visited health institutions, more emphasis was given to curative medicine and treatment (MCH) than family planning.

Despite the mentioned difficulties faced by the health institutions, the quality of family planning services provided seems to be adequate at least from the client's perspective at hospital and health center level. However, the limited choice of methods available in the health institutions, insufficient information given to clients about the available family planning methods, the possible side effects and their management, the lack of privacy during counselling and examination as well as the absence of follow-up mechanisms and, in general, providers bias towards other health service programs are of great concerns.

In light of the above analyses and discussions, the following recommendations are given to improve the quality of family planning services of the health institutions:-

- IEC materials were lacking in most service delivery points. Therefore adequate copies of posters and other educational materials with various family planning messages need to be designed and distributed to all the service delivery points. The existing one's should also be updated .
- All service delivery points should receive standardized reporting formats and service providers need to be given standard definitions for "Repeat" and "Continuing" acceptors. Furthermore, service providers need to be given regular training on MIS at all levels .
- The existence of strong supervisory mechanisms at all levels is critical for ensuring the quality of the service provided. Due to various constraints the existing supervisory system is rated to be poor by the service providers. Hence, there is a need to strengthen the supervisory capacity of the Regional Health Bureau, Zonal and Woreda health departments through the provision of adequate budget, and other facilities.
- Trained and skilled human resource is required to organize and conduct a family planning program. A continuous training program, therefore, should be organized and strengthened in all of the regions for those who are already in the service without having family planning training. Refresher courses should also be organized for former family planning trainees to update them with currently available technology.
- The method mix seems to be poor in the service delivery points in general and in clinics in particular. Thus, a concerted effort should be exerted to improve the method mix of the health institutions by making different family planning methods available. In addition, all the available methods should be addressed with equal vigor.
- Since most of the health institutions are supplied with condom and IUCD, greater effort should be made by these institutions to promote the use of these methods.
- The observed poor privacy during counselling and examination needs to be improved.

- Follow-up was virtually non-existent in all the visited health institutions. A mechanism, therefore, has to be established in the service delivery points to follow-up clients and minimize the number of defaulters.

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