

The Status of Family Planning Integration into Reproductive, Maternal, Newborn, and Child Health Services in Ethiopian Healthcare Facilities



Introduction

In Ethiopia, an estimated 4.5 million women of reproductive age have an unmet need for modern contraception (Sully et al. 2019). Offering integrated services is one of several promising high-impact practices in family planning (FP) (HIPs 2021). Reproductive, maternal, newborn, child, and adolescent health and nutrition (RMNCAH-N) services specifically serve as important opportunities to reach underserved clients in the extended postpartum and postabortion periods with FP counseling and services (Abate et al. 2020; Andualem et al. 2022). Yet, aside from few initiatives to integrate FP into HIV and AIDS care and the health extension worker program, progress in fully integrating FP into RMNCAH-N services at different levels of the primary healthcare system in Ethiopia, particularly in facility settings, remains slow (MOH 2020; MOH 2021; Titiyos et al. 2023).

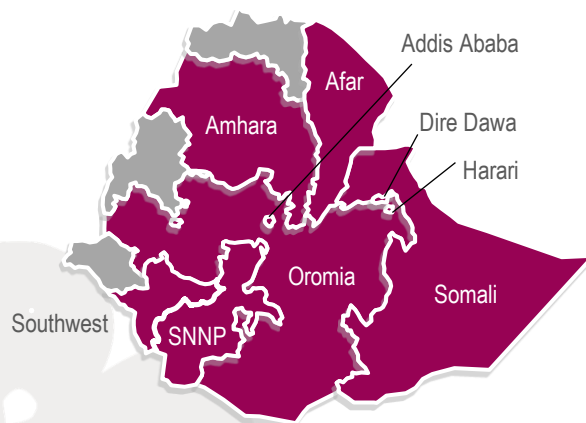
Understanding the status of FP integration at public health facilities across the country will help inform service integration needs. In 2021, EngenderHealth, with funding from the Bill & Melinda Gates Foundation, launched the Family Planning Integration in Ethiopia’s Primary Healthcare System project, which aimed to inform how FP could be integrated into RMNCAH-N services as part of the broader primary healthcare system.

Methodology

The project conducted a representative facility assessment in seven regions and two city administrations of Ethiopia¹ to determine the extent of integration of FP into antenatal care (ANC), postnatal care (PNC), postabortion care (PAC), and immunization services in three types of facilities: primary hospitals, health centers, and health posts (see Figure 1). Researchers selected a representative sample of 39 primary hospitals, 42 health centers, and 39 health posts to implement a mixed-method assessment. This included: (1) a facility readiness assessment to understand the extent to which providers are able to deliver FP counseling and services, (2) client exit interviews to assess the clients’ experiences, and (3) a review of health service data to understand FP client loads in the year prior to the study (July 2021 to June 2022).

Ethiopia’s primary healthcare system comprises of primary hospitals, health centers, and health posts. At the highest level, primary hospitals provide emergency, inpatient, and ambulatory services to an average population of 60,000 to 100,000. They also serve as referral sites for health centers. Health centers serve 25,000 people on average, with staff who offer preventative and curative services, in addition to serving as referral sites for health extension workers. At the lowest level, health posts are linked to each health center. These health posts are located closest to the communities, providing services for an average of 5,000 people.

Figure 1: Facility Assessment Coverage Area



We assessed a representative sample of:

- 39** primary hospitals
- 42** health centers
- 41** health posts

across seven regions and two city administrations of Ethiopia.

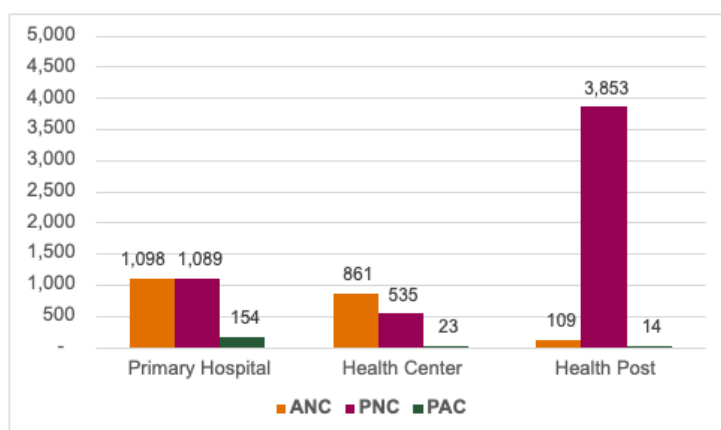
Results

Overview of Facilities and Facility Characteristics

Client Load

An analysis of facility service records from July 2021 to June 2022 showed that health posts have the highest client flow overall, with most clients visiting health posts for PNC; 97% of clients visited health posts for PNC compared with 47% of clients who visited primary hospitals and 38% who visited health centers (see Figure 2). Primary hospitals had similar numbers of ANC and PNC clients visiting their facilities, while health centers had fewer PNC clients than ANC clients. Very few clients visited health centers or health posts for PAC; PAC clients were more commonly recorded at primary hospitals.

Figure 2: Monthly Average Number of Clients Visiting Each Facility Type, by Client Type



Electricity and Water Supply

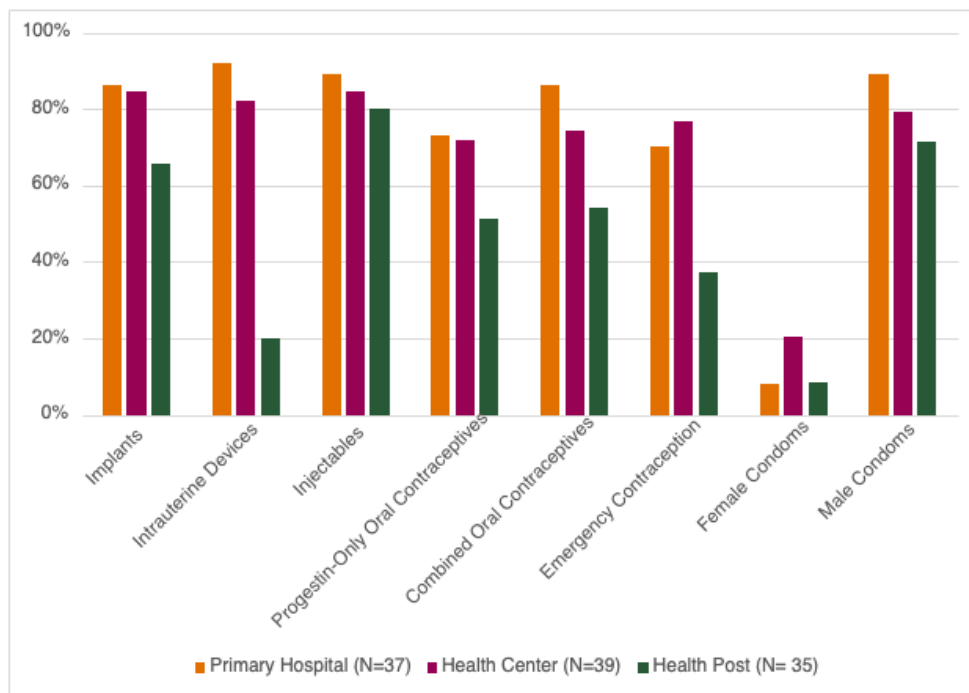
Our study identified varying electricity and water supply availability across facility types. Most facilities assessed are located in urban areas (95% of primary hospitals, 62% of health centers, and 32% of health posts). While over 90% of hospitals and health centers have electricity, most health posts lack electricity or water supply (66% and 76%, respectively).

Contraceptive Method Commodity Availability

Researchers also examined contraceptive commodity availability across facilities, recognizing that FP commodities are an essential component for FP integration. The study defined method availability as observation by researchers of the presence of at least one non-expired method of the various method types. Primary hospitals and health centers had similar levels of contraceptive availability across method types (Figure 3). Long-acting reversible contraceptives were available in more than 80% of these facilities. Short-term methods were available at more than 70% of primary hospitals and health centers, except for female condoms, which were rarely available. Among health posts, method availability was generally lower, with implants available at two-thirds of facilities and intrauterine devices available at only one-fifth of facilities. More than 50% of health posts had oral contraceptives available but less than 40% had emergency contraceptives. In addition to recording observations, researchers separately asked health service delivery point leads to report on method availability. The commodity availability directly observed by researchers often conflicted with the method availability reported by health facility service delivery point leads, with

facility service delivery point leads reporting higher method availability than observed. For example, 95% of health posts reported availability of combined oral contraceptives, but the commodity was only observed at 54% of health posts (data not shown).

Figure 3: Observed FP Method Commodity Availability at Surveyed Health Facilities (N=111)*



*Observation of commodity availability was possible at 111 out of the 122 surveyed facilities.

Our study also assessed commodity stockouts as an FP service readiness indicator. Based on findings from a three-month period prior to the study (exact dates varied by facility), the highest proportion of commodity stockouts were associated with combined oral contraceptives at health posts (54.3%, N=19) and injectables at health centers (51.3%; N=20) (not shown).

Facility Readiness for FP Integration Across Health Service Delivery Points

Among facilities assessed, all primary hospitals and health centers (100%) and most health posts (85.4%) offer ANC and PNC (see Table 1). Nearly all hospitals (97.4%) and most health centers (78.6%) offer PAC. Most facilities also offer immunization services. Few health posts (2.4%) offer PAC; thus we excluded those facilities from further analyses due to the small sample size. In the facilities identified as offering ANC, PNC, PAC, and/or immunization services, researchers assessed readiness for FP integration into these services by examining several key facility characteristics: facility operations, provision of FP counseling, and status of provider training on FP.

Facility Service Hours

All health centers and more than 90% of primary hospitals and health posts offering ANC, PNC, and PAC report that ANC, PNC, and PAC service hours overlap with FP service hours. Despite this, other signs of FP integration, such as providers completing and recording FP counseling information in client clinical histories, occurred less frequently. This was especially true for health posts providing ANC and PNC; only

37% of health posts providing ANC and 43% of health posts providing PNC recorded clients' FP counseling information.

Provision of FP Counseling

Most facilities—including more than 90% of primary hospitals and 95% of health centers offering ANC, PNC, and PAC—reported routinely offering FP counseling to clients accessing other health services. Results were similar in health posts, where 91% of facilities reported routinely offering FP counseling to antenatal clients and 89% reported routinely offering FP counseling to postnatal clients.

Table 1. Indicators of Facility Readiness for FP Integration

Indicators	Facilities Offering ANC			Facilities Offering PNC			Facilities Offering PAC	
	Primary Hospitals (N=39)	Health Centers (N=42)	Health Posts (N=35)	Primary Hospitals (N=39)	Health Centers (N=42)	Health Posts (N=35)	Primary Hospitals (N=38)	Health Centers (N=33)
Hours of operation of non-FP services (ANC, PNC, and PAC) coincide with hours of operation of FP services	97%	100%	100%	100%	100%	91%	100%	100%
FP counseling is routinely offered to ANC, PNC, and PAC clients	90%	95%	91%	100%	95%	89%	95%	100%
FP counseling information is recorded in ANC, PNC, and PAC clients' clinical histories	77%	86%	37%	87%	88%	43%	95%	82%

Providers Trained to Offer FP Counseling

The number of providers offering ANC, PNC, PAC, and immunization services who have received training on FP counseling varies but is generally low. For instance, of ANC providers, 38% at primary hospitals, 50% at health centers, and 69% at health posts have received FP counseling training. PNC providers were slightly more likely to have received FP counseling training, including 49% of providers at primary hospitals, 60% at health centers, and 71% at health posts. A similar proportion of PAC providers at primary hospitals and health centers received FP counseling training, 63% and 55% respectively. The proportion of immunization providers who have received FP counseling training ranged from 49% at primary hospitals to 71% at health posts.

Barriers to FP Integration

Facilities reported a series of barriers to providing FP services to ANC, PNC, PAC, and immunization clients (see Table 2). Across facility and service delivery types, the main difficulties reported in providing FP services for non-FP clients were a lack of supplies and providers who do not feel sufficiently trained. Many health posts reported inadequate facilities as the main barrier to FP service integration. Other challenges reported included lack of equipment and lack of qualified personnel.

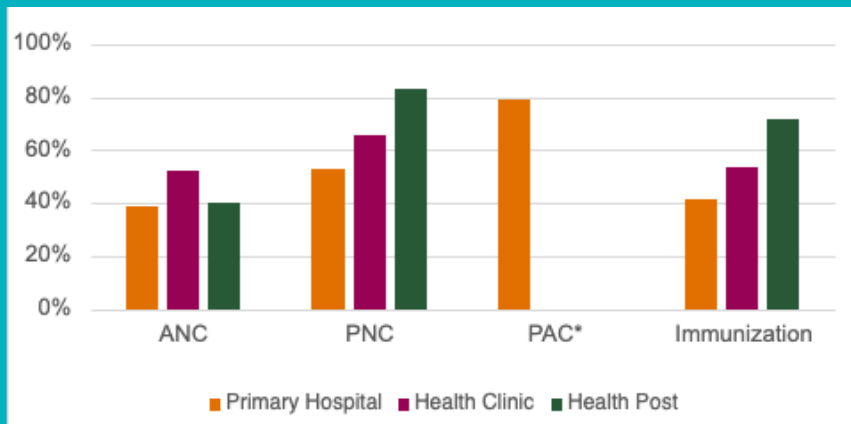
Table 2. Challenges to Integrating FP into Other Health Services

Type of Challenge	Primary Hospitals	Health Centers	Health Posts
Lack of supplies	43%	45%	57%
Lack of providers who feel sufficiently trained	39%	39%	48%
None	23%	26%	16%
Inadequate facilities	17%	17%	27%
Lack of equipment	21%	18%	21%
Lack of qualified personnel	18%	13%	19%
Insufficient time to counsel clients	15%	11%	13%
Other	15%	11%	8%
Equipment failure	10%	11%	11%

Client Exit Interview Insights

While facility assessment findings illustrated the almost universal provision of FP counseling, client exit interviews showed a different reality (see Figure 4). Among ANC clients surveyed, 38% of public hospital clients, 52% of health center clients, and 40% of health post clients reported receiving FP counseling during their visit. Among PNC clients surveyed, 53% of public hospital clients, 66% of health center clients, and 83% of health post clients reported receiving FP counseling during their visit. Reports from immunization clients were similar to those of PNC clients. Among PAC clients surveyed, 79% of public hospital clients reported receiving FP counseling during their visit. Despite the low reports of FP counseling, most ANC clients indicated plans to use FP following delivery (82%, 86%, and 77% at public hospitals, health centers, and health posts, respectively), as did most PNC clients (74%, 75%, and 94% at public hospitals, health centers, and health posts, respectively). Of the PAC clients counseled on FP at public hospitals, 87% were offered an FP method and 69% of those clients offered a method received the method the same day.

Figure 4. Percentage of Non-FP Clients Who Reported Receiving FP Counseling, by Facility Type



* Data not shown for PAC clients at health clinics and health posts due to small sample size.

Key Findings and Recommendations

- Most facilities surveyed offer ANC and PNC and offer FP services, suggesting that there is some integration of FP services. This is also true for PAC, except for health posts, which rarely offer PAC.
- While facility service delivery point leads reported that FP counseling is routinely offered to clients seeking other health services, a high proportion of non-FP clients reported not receiving FP counseling during their visits. This discrepancy between facility reports and the client experiences indicates a need for further inquiry to inform future interventions. It also suggests that while facilities may have integrated FP services in theory, this integration is not practiced to the extent that it benefits clients and is not monitored sufficiently by facilities. The discrepancy between reported and observed FP commodity availability similarly suggests a need for improved monitoring at the facilities and use of data for decision-making.
- The proportion of ANC, PNC, PAC, and immunization service providers who have received FP training is low. However, despite this lack of training, facility leads report that FP counseling is provided at high rates. These conflicting data, along with the client survey results, suggest that the quality of care is insufficient. This indicates a need to expand FP training and strengthen the capacity of providers to offer high-quality, integrated services.
- Providers reported challenges in delivering FP services to clients visiting facilities for non-FP services related to lack of supplies and not feeling sufficiently trained to offer care. Recommendations to address these gaps include improving FP commodity security and supply chain management in coordination with the Ethiopian Pharmaceutical Supply Agency, expanding provider FP training, and implementing supportive supervision and mentoring activities among staff at different health facility levels. Strengthening the data registry system to include additional elements related to FP integration could also support operational efficiencies.
- With high client loads, health posts offer opportunities to reach more people with integrated FP care, especially as they are closer to the communities and may be more accessible to greater numbers of clients. However, health posts frequently lack electricity and water supply, which are significant operational challenges. Health posts and their clients also report signs of lower FP integration than other facility types. Interventions should address equity in integrated FP service provision and institutionalization of integrated FP services at lower levels of the health system, including ensuring that basic needs are not overlooked. Contraceptive commodity availability is another crucial factor for FP service integration at this level.

Conclusion

Successful integration of high-quality FP into RMNCAH-N services requires strengthening the health system at various levels. At the facility-level, there is a particular need for expanding provider capacities to offer FP counseling and services. Supply-side interventions should consider activities that support provider training, supply-chain functions, and enhanced operations within facilities.

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References

- Abate, E., Smith, Y.R., Kindie, W., Girma, A., and Girma, Y. 2020. "Prevalence and Determinants of Post-Abortion Family Planning Utilization in a Tertiary Hospital of Northwest Ethiopia: A Cross Sectional Study." *Contraception and Reproductive Medicine* 5, no. 39 (December). doi: 10.1186/s40834-020-00143-4.
- Andualem, G., Aklilu, A., Belay, G., Feyisa, W., and Alemnew, F. 2022. "Factors Associated with Utilization of Modern Postpartum Family Planning Methods during the Extended Postpartum Period among Mothers Who Gave Birth in the Last 12 Months at Injibara Town, Northwest, Ethiopia: A Cross-Sectional Study." *Contraception and Reproductive Medicine* 7, no. 25 (December). doi: 10.1186/s40834-022-00191-y.
- Federal Democratic Republic of Ethiopia, Ministry of Health (MOH). 2020. *National Guideline for Family Planning Services in Ethiopia*. Addis Ababa: MOH. https://www.moh.gov.et/site/sites/default/files/2021-06/National%20Guideline%20final%20for%20Family%20Planning%202020%20edited-final%20version_August%2025_2020.pdf.
- High Impact Practices in Family Planning (HIPs). 2021. *Family Planning and Immunization Integration: Reaching Postpartum Women with Family Planning Services*. Washington, DC: United States Agency for International Development (USAID). <https://www.fphighimpactpractices.org/briefs/family-planning-and-immunization-integration/>.
- MOH. 2021. *Health Sector Transformation Plan II*. Addis Ababa: MOH.
- Sully, E.A., Biddlecom, A., Darroch, J.E., Riley, T., Ashford, L.S., Lince-Deroche, N., Firestein, L., and Murro, R. 2020. *Adding It Up: Investing in Sexual and Reproductive Health 2019*. New York: Guttmacher Institute. <https://www.guttmacher.org/report/adding-it-up-investing-in-sexual-reproductive-health-2019>.
- Titiyos, A., O'Connell, K.A., Yohannes, A., Agarwal, A., Kassaw, J., Seifu, A., Firdu, N., Shikur, B., Seid, S., and Assegid, M. 2023. *Integration of Family Planning within Ethiopia's Primary Healthcare Settings: A Desk Review from EngenderHealth's Family Planning Integration Project*. Washington, DC and Addis Ababa: EngenderHealth. <https://www.EngenderHealth.org/wp-content/uploads/2023/02/Ethiopia-FP-Integration-Desk-Review.pdf>.