Chapter 5 Family Planning Services

5.1 Background

5.1.1 ESPA 2004 Approach to Collection of Family Planning Services Information

Use of contraceptive methods to plan families may be desirable for many reasons, including the following:

- Couples may wish to limit family size or delay a desired pregnancy.
- Appropriate spacing of births benefits maternal and child health. Studies have shown that spacing births at least two to three years apart contributes significantly to decreasing infant mortality (Govindasamy et al., 1993; Rutstein, 2000). Although there are fewer studies on the effects of spacing births on maternal health, it is generally accepted that too frequent births result in maternal depletion of essential minerals and vitamins.
- Preventing pregnancies that may worsen chronic or acute illnesses, including HIV/AIDS, benefits women's health.

Key factors contributing to the appropriate, efficient, and continuous use of contraceptive methods (Murphy and Steele, 2000) include the following:

- The availability of a variety of contraception methods to address client preferences and client-specific suitability of method (from the point of view of society and health)
- Counseling and screening of clients for appropriateness of methods
- Client education, using visual aids to increase information retention regarding options, side effects, and appropriate use of the method
- Availability of infrastructure and resources necessary for providing quality family planning services: equipment for client examinations, service guidelines and protocols, trained staff, a service delivery setting that allows client privacy, and procedures for preventing infections
- Availability of other health services relevant for family planning clients. These include education and services for reproductive tract infections and sexually transmitted infections (RTI/STIs) and programs geared toward groups with special needs to improve access and appropriate utilization of family planning services.

To increase the appropriate use of family planning, contraceptive services and counseling should ideally be available wherever maternal health, reproductive health, or child health services are provided.

This chapter uses information obtained in the ESPA 2004 to address the following central questions about the delivery of family planning services:

- What is the availability of family planning services?

- To what extent do the facilities offering family planning services have the infrastructure, resources, and supportive management required to support quality services?

5.1.2 Family Planning Services in Egypt

The Ministry of Health and Population (MOHP) reproductive health and family planning clinics constitute the majority of all family planning clinics in Egypt. During the past year, in response to a communication from the Minister of Health and Population, all MOHP facilities are encouraged to offer family planning services. This includes categories of facilities (such as fever hospitals) that previously did not offer the service. At the end of 2004, the MOHP reported there were 5,111 family planning clinics run by MOHP. The MOHP family planning clinics include rural health units (rural HUs), maternal and child health/urban health units (MCH/urban HUs), clinics at general service (GS) hospitals (these include general, district, and integrated hospitals), and mobile units.

Use of reproductive health services has been increasing over the years, with modern contraceptive use increasing between 1980 and 2003 from 24 to 60 percent of currently married women age 15-49. Most of the increase took place in the late 1980s, with virtually no change in the overall rate of use between 1991 and 1995, followed by another increase between 1995 and 1997 (El-Zanaty and Way, 2004). The 2003 Egypt Interim Demographic and Health Survey (EIDHS 2003) documented 57 percent of currently married women of reproductive age using modern methods of contraception. The intrauterine device (IUD) is the most widely used method, followed by the oral contraceptive pill (37 and 9 percent, respectively). The majority of the pill users (82 percent) obtain their methods from a private pharmacy. Two-thirds (61 percent) of all IUD users go to public sector facilities.

The Population and Family Planning Program has been relatively effective over time. Total fertility has decreased from 5.3 children per woman (age 15-49 years) in 1979-1980 to 3.2 in 2003. Success has been uneven across the country, with fertility rates higher in rural (3.6) than in urban areas (2.6), and higher in Upper (3.8) than in Lower Egypt (3.1) and in the Urban Governorates (2.3) (El-Zanaty and Way, 2004).

5.2 Availability of Family Planning Services

Methods of family planning differ in how they function, their effectiveness, their side effects, the ease with which they can be administered, and, in view of these issues, their acceptability and desirability to the users. To meet the varying needs and demands for contraception, a variety of methods should be available at a frequency that meets common needs (Curtis and Bright, 1997).

The modern methods most commonly used in Egypt (El-Zanaty and Way, 2004) are—

- IUDs
- Contraceptive pills
- Contraceptive injections.

Other, less commonly used methods include the progesterone implant, male condoms (female condoms are not available), female sterilization, rhythm (natural family planning), diaphragm, spermicides, and emergency contraception. Male sterilization is not available in Egypt, and female sterilization, while offered, is primarily considered for birth control only when a woman has a health condition that makes pregnancy a serious health risk.

Summary information on the availability of family planning services is provided in Table 5.1, and information on the frequency with which family planning services are offered is provided in Table 5.2. Figure 5.1 provides details on the availability of different methods of contraception, and Appendix Tables A-5.1 through A-5.3 provide further details on method availability by type of facility and region.

Table 5.1 Availability of family planning services

Percentage of all eligible facilities offering the indicated methods of family planning, by type of facility and region, Egypt SPA 2004

Background characteristics	Facilities eligible for offering family planning (FP) services		Among facilities offering any modern methods of family planning:		
	Percentage offering any modern method of FP[1]	Number of facilities (weighted)	Percentage offering all four of the most common methods[2]	Percentage offering counseling on rhythm method	Number of facilities (weighted)
Type of facility					
GS hospital	100	65	95	64	65
Fever hospital	10	14	100	52	1
MCH/urban HU	98	97	92	70	96
Rural HU	100	319	86	70	319
Mobile unit	100	55	87	63	55
Health office[3]	86	33	70	62	28
NGO facility	95	76	57	58	72
Region					
Urban Governorates	98	72	70	58	71
Lower Egypt	97	322	93	78	312
Upper Egypt	96	264	76	55	253
Total	97	659	84	67	637

[1] Any of the following: contraceptive pills (combined or progesterone only), injections (combined or progesterone only), implants, IUDs, male condoms, spermicides, diaphragm, or emergency contraceptive. Permanent methods (sterilization) are not included.
[2] The four most common methods used in Egypt are the IUD, the combined oral pill, the progesterone injection, and the male condom.
[3] Often, health offices are located in a hospital or MCH unit. In these cases, family planning services may be offered by the hospital or MCH unit, rather than through the health office.

5.2.1 Method Availability

A facility that offers all methods of family planning is best able to meet the needs of clients. However, some variation in the methods that facilities offer is expected because of differences in the provider qualifications and training, as well as infrastructure required to provide the methods safely. Methods that can be provided safely with minimal training are pills, injections, and condoms, as well as the rhythm method. Implants and IUDs require a higher level of skill and a more developed infrastructure to provide safely.

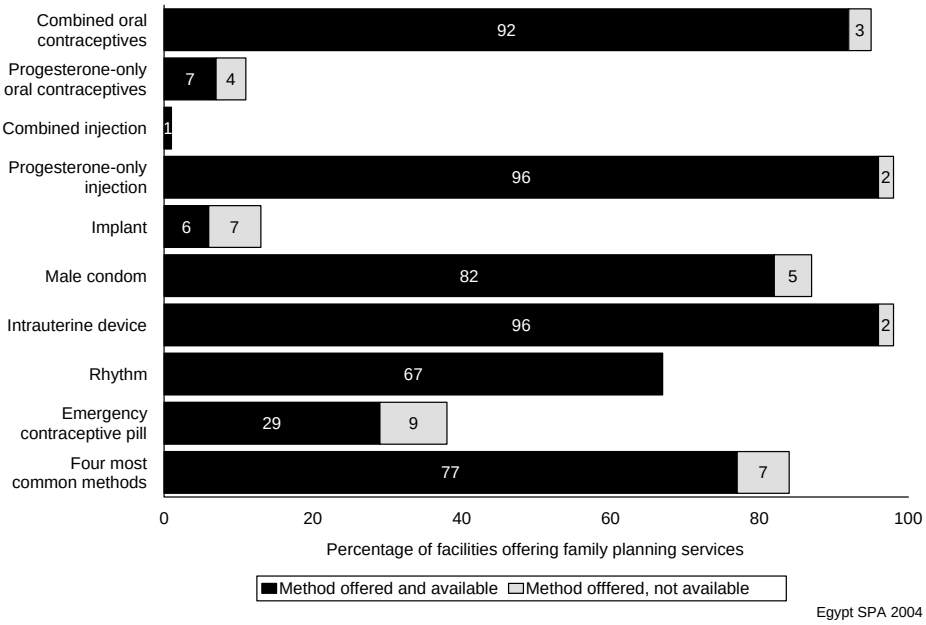
From 2002 to 2004, the proportion of eligible facilities offering a modern method of family planning has remained stable,[1] at 97 percent, with 84 percent offering all of the four most common methods (Table 5.1)

[1] In 2004, fever hospitals were beginning to offer family planning services in response to a policy directive from MOHP.

and 77 percent having a supply of all four methods on the day of the survey (Figure 5.1). Sixty-seven percent of facilities offer counseling on the rhythm method, a decrease from 78 percent in 2002. A larger proportion of facilities in Lower Egypt offer the four most common methods (93 percent), compared with those in the Urban Governorates (70 percent). NGO facilities offer less variety in methods, with only 57 percent offering the four most commonly used methods. The proportion of health offices offering the four methods has substantially decreased, from 89 percent in 2002 to 70 percent in 2004. Four percent of facilities report that they offer female sterilization as a method of birth control; this is a slight increase over the 2 percent in 2002, with GS hospitals continuing to be the main service site (25 percent) (Appendix Table A-5.1). Fifteen percent of GS hospitals offered female sterilization in 2002. The percentage of facilities that provide tubal procedures may be higher than this because, in Egypt, tubal ligation is more often provided for medical reasons than for family planning purposes.

Although the proportion of facilities offering the most commonly used methods had remained stable, a shift in the offering of less popular methods, however, has been noted, with the supply of the less frequently used methods, where offered, being a problem both in 2002 and 2004.

Figure 5.1 Method of contraception offered and availability of method on the day of the survey (N=637)



The proportion of facilities offering the implant method has increased from 8 percent in 2002 to 13 percent in 2004, although, as in 2002, supply remains a problem, with implants actually available at only half of the facilities where offered, on the day of the survey (Figure 5.1). From 2002 to 2004, although still available across Egypt, Norplant was slowly being replaced by Implanon, a new brand of implant with three-year protection (data not shown). Because of the relatively short period of validity for implant methods, they are not commodities for which a facility should maintain a three-month supply, as per the MOHP logistic strategy for commodity security.

Emergency contraceptive pills are offered at 38 percent of facilities (a decrease from 54 percent in 2002), with one in four facilities lacking an emergency contraceptive method the day of the survey. The progesterone-only pills (which can be used for emergency contraception) are offered at a smaller proportion of facilities (11 percent in 2004, compared with 53 percent in 2002) and also have supply problems. Progesterone-only pills and emergency contraceptive pills are not routinely procured for

MOHP family planning services. The combined injectable method continues to be offered rarely (1 percent of facilities) and primarily by NGO facilities (6 percent) (Appendix Table A-5.1).

5.2.2 Frequency of Services

In addition to providing a range of methods, it is important that family planning services be offered regularly to meet client needs. Similar to findings in 2002, family planning services are offered five days per week by almost all facilities (95 percent) that provide family planning services (Table 5.2). NGO facilities and health offices offer services the least frequently of all facilities.

Table 5.2 Frequency of availability of family planning services

Percentage of facilities where temporary methods of family planning are offered the indicated number of days per week, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage of facilities where family planning (FP)[1] services are offered: 1-2 days per week	3-4 days per week	5 or more days per week	Number of facilities offering FP services (weighted)
Type of facility				
GS hospital	0	0	100	65
Fever hospital	0	0	100	1
MCH/urban HU	0	0	100	96
Rural HU	1	3	97	319
Mobile unit	0	0	100	55
Health office	7	8	85	28
NGO facility	14	14	72	72
Region				
Urban Governorates	4	5	92	71
Lower Egypt	1	3	96	312
Upper Egypt	4	2	94	253
Total	2	3	95	637

[1] Any of the following methods: oral contraceptives (combined or progesterone only), injections (combined or progesterone only), implants, IUDs, male condoms (female condoms are not available), spermicides, diaphragm, or emergency contraceptive

Key Findings

From 2002 to 2004, the proportion of health facilities offering a modern method of family planning remains at 97 percent, with 84 percent offering all four most common methods and 95 percent of facilities offering services at least five days per week.

The supply for the four most commonly used methods is reliable, with 77 percent of facilities offering the four methods (combined oral contraceptives, progesterone injection, male condom, and IUD) and having all four methods available on the day of the survey.

There has been a shift among the less commonly used methods, with a smaller proportion of facilities in 2004 offering progesterone-only oral pills and emergency contraception, but a slightly larger proportion offering implants. The supply for less frequently used methods is less reliable than that for the more commonly used methods.

NGO facilities offer the least variety in methods, with only 57 percent offering the four most commonly used methods.

5.3 Components Supporting Quality Family Planning Services

In order to provide family planning services, adequate infrastructure and resources must be available to support quality counseling and examination of family planning clients. In addition, provision of RTI/STI services, relevant to family planning clients (STI services), and the equipment and supplies for each offered method are important.

5.3.1 Infrastructure and Resources to Support Quality Assessment and Counseling of Family Planning Clients[2]

For quality counseling for family planning, there is a need for some level of privacy, individual client health cards or records, written service guidelines or protocols, and visual aids.

Aggregate information for items to support quality counseling is provided in Table 5.3, and information on the availability of each specific item for counseling is provided in Figure 5.2. Details on the items assessed for each of the components for counseling are provided in Appendix Table A-5.4, and details on available visual aids and guidelines, by type of facility, are provided in Appendix Table A-5.5.

Family planning is often a sensitive issue for discussion, and providing counseling under conditions where clients can be reasonably assured that the conversation cannot be overheard improves communication and, ultimately, the likelihood that the method provided is suitable for the client. Privacy for counseling is almost universally available, with 86 percent of facilities (Figure 5.2) counseling family planning clients in either a private room (79 percent) or a room where there is a visual screen (7 percent) (Appendix Table A-5.4).

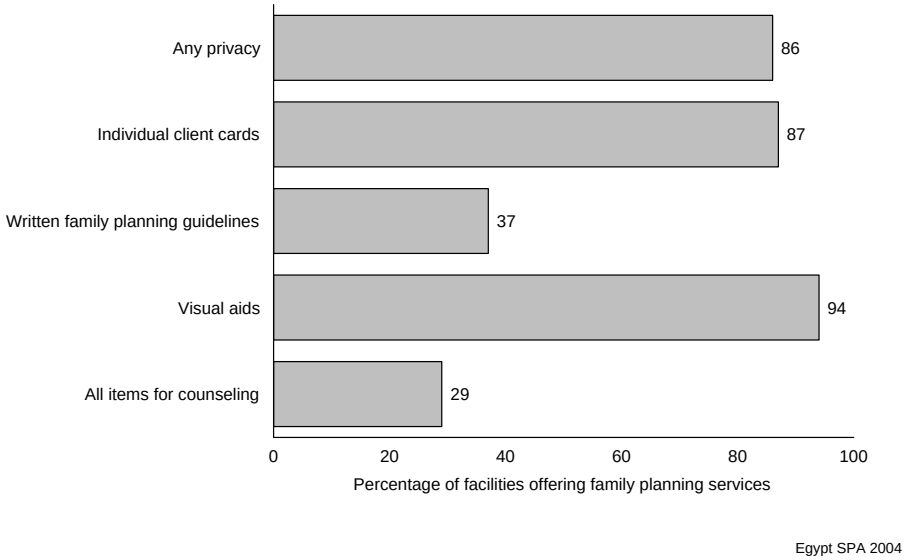
Individual cards or records for family planning clients are important for monitoring a client over time and for ensuring continuity of care. Because facilities often do not keep client records, but rather give them to the clients to keep, the ESPA 2004 assesses the availability of blank cards for new family planning clients. Individual client cards are found at 87 percent of facilities (Figure 5.2).

[2] Counseling about family planning often takes place in a location different from where procedures (e.g., pelvic examinations, IUD insertions) are conducted; thus, the conditions for counseling are assessed separately from those for procedures.

Written guidelines or protocols for family planning that include information on screening for eligibility for different methods must be available in the family planning service delivery area or in an immediately adjacent area to be considered available for use. Guidelines or protocols are available in the family planning service area in only 37 percent of facilities (Figure 5.2). This is a decrease from 46 percent in 2002.

Visual aids related to family planning are available in the service delivery area in 94 percent of facilities (Figure 5.2), similar to findings in 2002.

Figure 5.2 Items to support quality counseling for family planning
(N=637)



All assessed items to support quality counseling are available in 29 percent of facilities (Table 5.3), a decline from 37 percent in 2002, due principally to a smaller proportion of facilities having service guidelines or protocols. NGO facilities, mobile units, and facilities in Upper Egypt are least likely to have all items.

5.3.2 Infrastructure and Resources for Examinations

Frequently, a physical examination, often including a pelvic examination, is necessary to determine the suitability of a method, to insert a method, or to evaluate problems with a method. This requires an adequate level of infection control as well as infrastructure and furnishing for examining the client.

Aggregate information for items assessed for infection control and pelvic examinations is provided in Table 5.3, and information on the availability of each specific item for infection control and pelvic examinations is shown in Figure 5.3. Details on the items assessed for each of the components are provided, by type of facility, in Appendix Table A-5.4, and details on processing equipment are given in Appendix Tables A-5.6 through A-5.9.

Infection Control

The ESPA 2004 assesses the presence of items for the control of infections in the area where family planning examinations (such as pelvic examinations) and provision of methods (the implant, IUD, and injection) most often take place. All items for infection control (hand-washing supplies, clean or sterile latex gloves, disinfecting solution, and a sharps box) are available in the family planning service area in one of five facilities (18 percent) (Table 5.3). All items are present in a higher proportion of facilities in Lower Egypt (one in four) and in MCH/urban HUs (one in three) than in other regions or types of facilities. MOHP infection control guidelines are found in only 4 percent of the family planning service areas (Appendix Table A-5.5).

The items most often lacking are latex gloves (missing in 70 percent of facilities), followed by soap and sharps boxes (both items missing in approximately one-third of facilities) (Figure 5.3). From 2002 to 2004, soap provision has improved, with availability increasing from 51 percent in 2002 to 67 percent in 2004. Availability of sharps boxes has not changed.

The percentage of facilities with latex examination gloves decreased from 50 percent (2002) to 30 percent (2004). As explained in more detail in section 3.4.3, this may reflect more accurate data collection, rather than a change in availability of gloves. Thin, nonlatex disposable gloves are universally available in all service areas where pelvic examinations are conducted, but these are not accepted for infection control. This point was emphasized more during the ESPA 2004 training than it was in 2002.

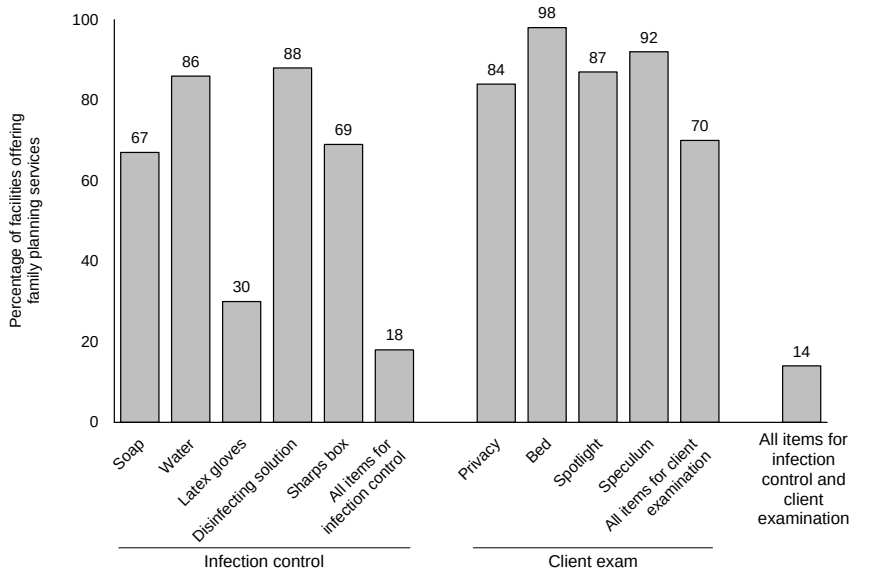
Table 5.3 Availability of infrastructure and resources to support quality services for temporary methods of family planning

Percentage of facilities with the indicated elements to support quality counseling, examination, and treatment of FP clients, by type of facility and region, Egypt SPA 2004

Background characteristics	Percentage of facilities with: All items to support quality counseling[1]	All items for infection control[2]	Capacity for sterilization/ HLD processing[3]	Conditions for quality pelvic examination[4]	STI treatment provided by FP providers	Number of facilities offering FP (weighted)[5]
Type of facility						
GS hospital	45	23	61	83	88	65
MCH/urban HU	39	31	84	75	87	96
Rural HU	30	17	51	67	79	319
Mobile unit	6	12	81	65	82	55
Health office	25	4	40	46	64	28
NGO facility	13	11	38	75	86	72
Region						
Urban Governorates	24	11	67	78	93	71
Lower Egypt	38	24	57	63	85	312
Upper Egypt	19	13	56	76	73	253
Total[5]	29	18	57	70	81	637

[1] Visual privacy, individual client cards, written guidelines or protocols related to family planning, and visual aids related to family planning
[2] Soap, water, clean latex gloves, disinfecting solution, and sharps box
[3] In location where family planning equipment is processed, equipment and knowledge of minimum processing time for sterilizing or high-level disinfection (HLD) processing are present, and an automatic timing device is available
[4] Private room (visual and auditory privacy), examination bed, examination light, and vaginal speculum
[5] One fever hospital offers family planning.

Figure 5.3 Conditions for quality examination of family planning clients (N=637)



Egypt SPA 2004

Equipment for family planning services often requires sterilization or high-level disinfection (HLD) so that it can be reused. Around half of all facilities process equipment specifically in the family planning service area, and the rest send equipment to the main processing area in the facility (Appendix Table A-5.6). Overall, 87 percent of facilities have functioning equipment and a person who knows the proper processing procedure for the sterilization or HLD method used for family planning equipment[3] (Appendix Table A-5.7). This is somewhat higher than findings in 2002 (78 percent). An automatic timing device is also important for supporting quality sterilization or HLD processing. When this criteria is added, 57 percent of facilities have the equipment, knowledge, and an automatic timing device (Table 5.3), with the timing device missing most often for facilities where HLD processing (boiling, steaming, or using chemicals) is used.

Examination

Conditions for examination of family planning clients have not changed from 2002 to 2004, with 70 percent of facilities having all items for conducting examinations such as pelvic exams or implant insertions (Table 5.3). The weak areas are a lack of sufficient privacy (16 percent) and lack of a spotlight for visualizing the cervix or implant site (13 percent) (Figure 5.3). Health offices continue to be least likely to have all the equipment and furnishings for client examination (46 percent).

5.3.3 Provision of RTI/STI Treatment for Family Planning Clients

Because they are sexually active, family planning clients are at increased risk for contracting STIs. Consequently, counseling for prevention, as well as diagnosis and treatment, is essential for quality family planning care. It is particularly important to diagnose and treat STIs and other vaginal infections for women who use the IUD, the modern method most commonly used in Egypt. If these services are

[3] In Chapter 3, sections 3.4.1 and 3.4.2 provide details on the definitions for adequate sterilization or HLD procedures and for appropriate storage conditions, respectively.

available at the same time and place as family planning services, it is more likely that clients will have the necessary exams and will receive the appropriate treatment for an RTI/STI if needed.

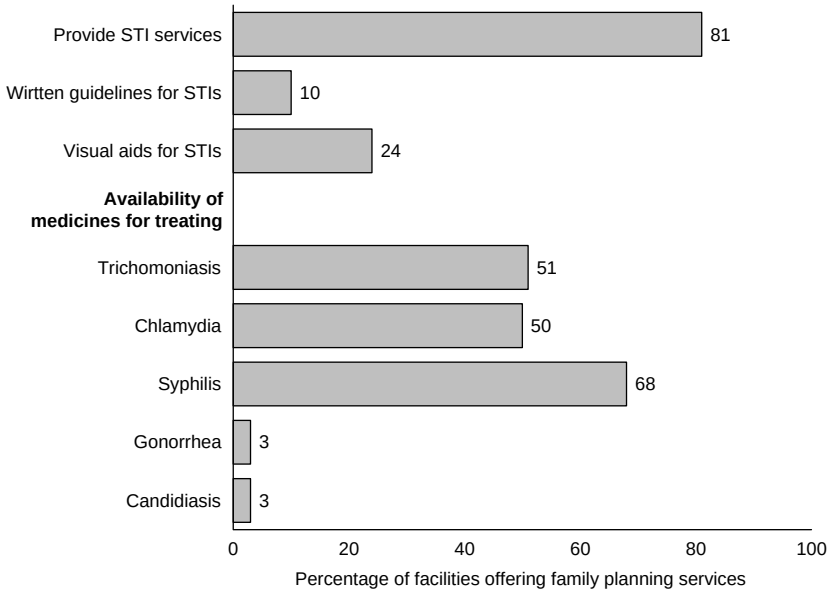
Figure 5.4 provides information on items for RTI/STI services. Appendix Table A-5.10 provides details, by type of facility, on the RTI/STI service items, including medicines for treating specific STIs.

There has been no change since 2002 in the percentage of facilities (81 percent) where family planning service providers diagnose and treat STIs when necessary (Table 5.3 and Figure 5.4). The provision of RTI/STI services by family planning providers was observed, with 38 percent of the 541 observed RTI/STI clients receiving both family planning and RTI/STI services from the family planning service provider (Table A-7.10).

Written guidelines for diagnosis and treatment of STIs are available in the family planning service area in 10 percent of facilities (Figure 5.4), with the World Health Organization (WHO) syndromic approach guidelines found in only 1 percent of facilities (Appendix Table A-5.5). This is lower than in 2002, when 15 percent of facilities had RTI/STI treatment guidelines and 7 percent had WHO guidelines for the syndromic approach. Visual aids for client education related to STIs are available in 24 percent of facilities.

Treatment for each of the three most common STIs is available in half of facilities (Figure 5.4), while medicine for treating gonorrhea and candidiasis (a common infection) is available in only 3 percent of facilities (Figure 5.4). These findings are slightly worse than the 2002 findings.

Figure 5.4 Conditions to support quality STI services for family planning clients (N=637)



Egypt SPA 2004

Key Findings

Privacy for family planning counseling services, individual family planning client cards, and visual aids are commonly available (at around nine in ten facilities).

Guidelines or protocols for family planning, however, are not available in two-thirds of facilities.

All assessed items for infection control are available in the family planning service area in 18 percent of facilities, with latex gloves the most commonly missing item (missing in 70 percent of facilities).

Fifty-seven percent of facilities have all elements for quality sterilization or HLD processing of family planning equipment.

All furnishings and equipment for pelvic examinations are available in 70 percent of facilities.

STI service provision by family planning providers is common (81 percent of facilities), but availability of medicines to treat STIs and common vaginal infections is low. Only 3 percent of facilities offering family planning services have medicines for treating candidiasis or gonorrhea.

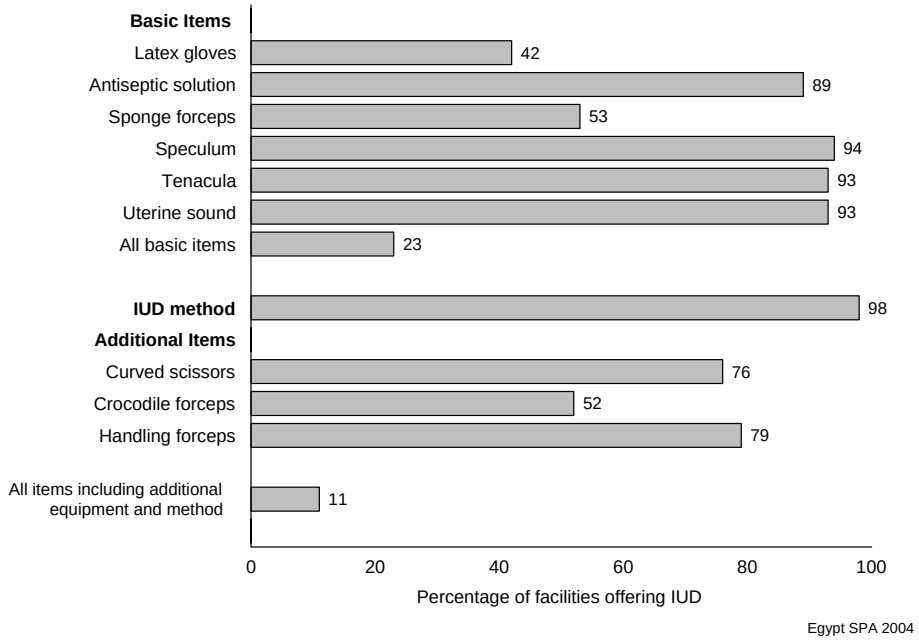
5.3.4 Availability of Equipment and Supplies for Specific Methods

Different contraceptive methods require different equipment to provide the method safely and to monitor the client. Figure 5.5 provides information to assess the availability of items basic to the provision of the IUD. Appendix Tables A-5.11 through 5.13 provide additional details on the availability of equipment and supplies for specific methods, including the IUD and implant methods.

Women receiving family planning methods with estrogen need to be monitored for hypertension. Among facilities providing methods containing estrogen, 89 percent have a blood pressure apparatus and 72 percent have an adult weighing scale (Appendix Table A-5.11). Among those providing injectable contraceptives, 85 percent have sterile needles and syringes (Appendix Table A-5.11). In Egypt, each progesterone injection vial is supplied with a syringe; so it is possible that 2 percent of the facilities without sterile needles and syringes were those facilities without progesterone injection available the day of the survey (Figure 5.1). Why syringes are missing for the other 13 percent is uncertain. It is possible that syringes were used elsewhere. Availability of these items is similar to or slightly lower than findings in 2002.

Among those facilities offering IUDs, 23 percent have the basic equipment necessary for insertion (Figure 5.5). Although this is a decline from 39 percent in 2002, the difference is due primarily to a decrease in availability of latex gloves. As mentioned previously, this probably reflects a more accurate assessment of gloves as latex or nonlatex in 2004. There is also a decline in availability of sponge forceps (53 percent in 2004, compared with 74 percent in 2002). In total, 11 percent of the facilities offering the IUD method have all of the basic equipment for insertion and additional items that were assessed for quality insertion and removal of the IUD (Figure 5.5).

Figure 5.5 Equipment for IUD insertion and removal (N=625)



Key Findings

Blood pressure equipment is available in 89 percent of facilities offering family planning methods containing estrogen.

Although IUDs are one of the most commonly provided contraceptive methods, only 23 percent of facilities have all items necessary for quality IUD insertion.

5.4 Management Practices Supportive of Quality Family Planning Services

Management practices for supporting quality family planning services include documentation and records, practices related to user fees, and staff supervision and development.

Summary information on management practices is provided in Table 5.4. Information on topics for in-service training and when training was received is provided in Figure 5.6. Utilization statistics for family planning services are provided in Appendix Table A-5.14. Details on charging practices for family planning services are provided in Appendix Tables A-5.15 through A-5.17. Details on in-service training and supervisory activities from the provider's perspective are provided in Appendix Tables A-5.18 through A-5.20.

5.4.1 Facility Documentation and Records

The ESPA 2004 assesses the availability of up-to-date client registers with information on family planning services provided. This is most often the source of health information system data. A register is defined as up to date if there is an entry within the past seven days, and the entry, at minimum, reports the method or service provided and the client's status (first visit or followup visit). Almost all (91 percent) facilities have an up-to-date register (Table 5.4), with the exception of NGO facilities, where only about half have an up-to-date family planning register.

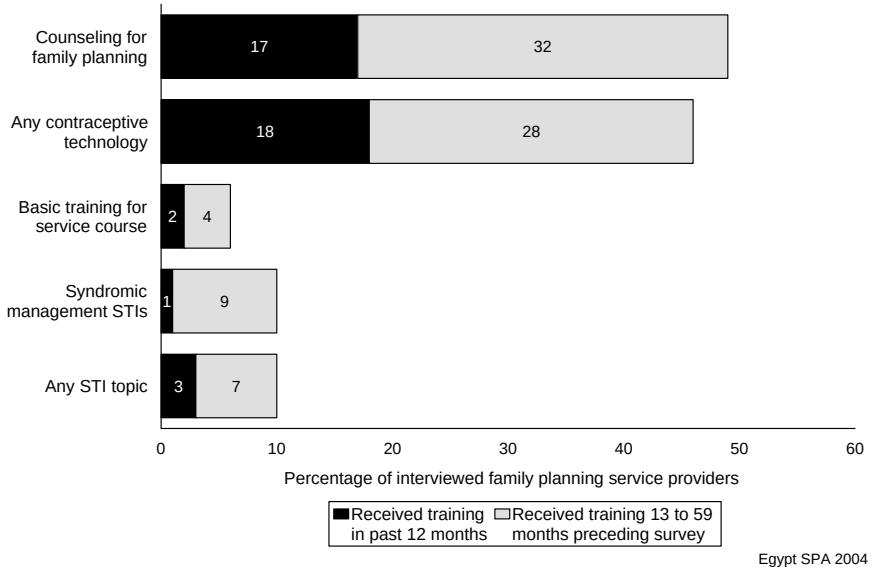
Table 5.4 Management practices to support quality services for temporary methods of family planning

Percentage of facilities with up-to-date family planning (FP) registers, percentage where there are some user fees for family planning services, and percentage with the indicated supportive management practices, by type of facility and region, Egypt SPA 2004

Background characteristics	Facilities that offer family planning services		Number of facilities offering FP (weighted)	Percentage of facilities where at least half of the interviewed FP service providers		Number of facilities with interviewed FP service providers (weighted)[3]
	Percentage with observed up-to-date patient register[1]	Percentage with user fees for FP services		Received in-service training during past 12 months[2]	Were personally supervised during past 6 months	
Type of facility						
GS hospital	99	97	65	28	96	65
Fever hospital	100	100	1	100	100	1
MCH/urban HU	96	99	96	35	98	96
Rural HU	96	98	319	15	99	319
Mobile unit	95	36	55	39	88	55
Health office	89	84	28	37	100	27
NGO facility	49	97	72	17	57	71
Region						
Urban Governorates	82	92	71	26	83	71
Lower Egypt	93	94	312	19	95	312
Upper Egypt	90	90	253	27	93	251
Total	91	92	637	23	93	635

[1] Register has entry within past seven days and indicates visit status (first or followup) and service provided.
[2] This refers to structured in-service sessions and does not include individual instruction received during routine supervision.
[3] This includes only providers of family planning services in facilities offering family planning services.

Figure 5.6 In-service training received by interviewed family planning service providers, by topic and timing of most recent training (N=1,294)



5.4.2 Practices Related to User Fees

Health insurance is not applicable for family planning clients in public sector facilities. Information on user fees is similar for 2002 and 2004. Most facilities (92 percent) have some type of user fees for family planning services (Table 5.4).

5.4.3 Supervision and Staff Development

The types of contraceptive methods that are available and knowledge of the benefits and side effects of methods change over time. In-service training for providers aims to improve the quality of counseling, management of complications or side effects, and judgment and skills in assessing which contraceptive methods are most suitable for clients' needs.

If at least half of the interviewed family planning service providers at a facility have received any structured in-service training (excluding on-the-job training that may be received during discussions with supervisors) relevant to family planning during the past 12 months, the facility is defined as having routine staff development. During the past 12 months, at least half of the interviewed family planning providers had received in-service training related to family planning in only 23 percent of facilities (Table 5.4). Counseling for family planning and contraceptive technology are the topics most often covered, with about 17 percent of the providers having received in-service training in at least one of these subjects during the past 12 months; with an additional one in three providers receiving in-service training during the 13 to 59 months preceding the survey (Figure 5.6). One percent of the interviewed family planning providers had received in-service training on syndromic management of STIs, and 3 percent had received training on any topic related to STIs during the past 12 months, with an additional 7 percent having received in-service training on a topic related to STIs during the 13 to 59 months preceding the survey. The percentage of staff receiving in-service training on topics related to STIs has decreased by half since 2002. A large decrease was noted in the percentage of providers who received an in-service basic training course for family planning during the five years preceding the survey (from 34 percent in 2002 to 6 percent in 2004) (Appendix Table A-5.19). This might be a reflection of a better understanding by interviewers of the definition of this course (the 2002 data collectors may have included preservice training on family planning as "basic training"). It was clarified in 2004 that the basic training course only referred to in-service training.

Supervision of individual staff helps to promote adherence to standards and to identify problems that contribute to poor-quality services. If at least half of the interviewed family planning service providers in a facility have been personally supervised in the past six months, the facility is defined as providing routine staff supervision. Similar to findings in other services, supervision of family planning providers is common, with at least half of the interviewed family planning providers having been supervised during the past six months in 93 percent of facilities (Table 5.4). Among providers who had been supervised, the median number of times they were supervised during the past six months was seven (Appendix Table A-5.20). These findings are similar to those in 2002.

Key Findings

Up-to-date registers are available almost universally (91 percent of facilities), except in NGO facilities, where they are found in only half of facilities.

Formal in-service training for family planning is routinely provided by only one in five facilities.

5.5 Adherence to Standards for Quality Service Provision

Observed family planning client-provider consultations are the basis for assessing whether providers adhere to standards for quality service. The observation checklists used are based on commonly accepted guidelines for screening, counseling, and conducting procedures for family planning clients.

The objective in the observations of the consultations is to note if information on a topic is shared or if an examination is conducted (process information). An assessment of whether the information is correct or whether findings are appropriately interpreted is not a component of the observation.

A total of 1,959 female clients were observed at 523 facilities.[4] This was the first visit for 31 percent of the women, and 1 percent had no prior pregnancy (Appendix Table A-5.21). Exit interviews were conducted with all observed family planning clients. When two methods were prescribed or received, the client was assessed for knowledge about both their current method and the new method. Clients who left the facility with no method, but had prescriptions for a method, were also assessed for their knowledge about the prescribed method.

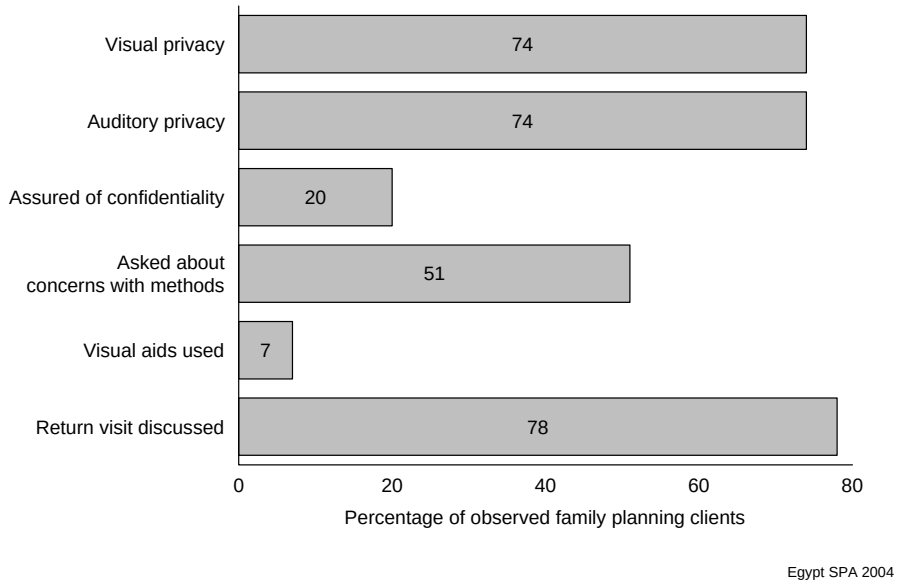
Further details on the observed client status and principal reason for the clinic visit on the day of the survey are provided in Appendix Table A-5.22. Details on the primary method provided, prescribed, or discussed during this visit are provided in Appendix Table A-5.23.

5.5.1 Assessment of Relevant History, Examination, and Counseling

Figure 5.7 provides information on components of family planning related to counseling, Figure 5.8 provides information on elements of the client history that were assessed for first-visit family planning clients, and Figures 5.9 through 5.12 provide information for consultations where clients received specific methods or procedures. Details on elements related to the consultation for first-visit clients are provided in Appendix Tables A-5.24 through A-5.26. Information from observations related to specific methods or examinations is provided in Appendix Tables A-5.27 and A-5.28.

[4] These are actual numbers. Data in tables and figures are weighted to provide accurate representation by type of facility and governorate.

Figure 5.7 Observed conditions and content for family planning counseling (N=1,930)



5.5.2 Counseling and Client Assessment

Counseling was conducted under conditions of both visual and auditory privacy for 74 percent of clients (Figure 5.7). Clients were rarely explicitly assured of the confidentiality of information shared (20 percent). Half of the clients, however, were explicitly asked about concerns about the methods discussed, and 78 percent were advised about a return visit. Visual aids were rarely used (7 percent) during the consultation. Privacy and confidentiality are somewhat improved from 2002, when 65 percent of observed family planning clients had full privacy and 14 percent were explicitly assured of the confidentiality of information shared.

Individual client cards are necessary to monitor a family planning client over time and to document relevant history so that it does not need to be collected multiple times. Frequently, health services are organized in such a way that measurements of blood pressure, weight, and other components of a consultation take place before the provider responsible for the consultation sees the client, and the information is recorded on a client record. This is the system for 31 percent of facilities (data not shown), similar to what was observed in 2002. An individual client record or chart is important for ensuring that information collected prior to the consultation is available to the provider. Among the observed consultations, the provider reviewed the client card either before or during the consultation for 66 percent of clients and wrote on the card after the consultation for 76 percent of clients (Appendix Table A-5.24). This is an improvement in practices to support continuity of care; in 2002, the provider was observed checking the client card for only 48 percent of consultations and writing on the card for 65 percent of the observed consultations.

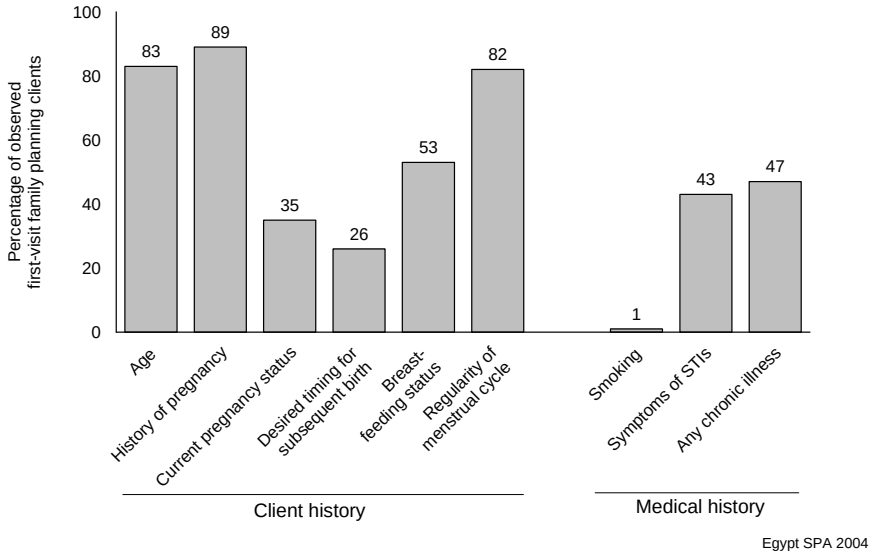
The assessment of relevant history for first-visit family planning clients continues to be incomplete, similar to findings in 2002. Among first-visit family planning clients, the provider should elicit relevant personal and health history that provides the information necessary to make an informed recommendation on contraceptive methods and to screen clients for the safety of specific methods. Client age, prior pregnancy history, and information on the regularity of the menstrual cycle were each assessed for over

80 percent of first-visit clients (Figure 5.8). Current pregnancy status (either ascertained through information sharing or through laboratory testing) and desired timing for the next pregnancy were the least frequently elicited items of client history (35 and 26 percent, respectively). Breastfeeding status, essential to ascertain when determining the suitability of different methods of contraception, was elicited for about half (53 percent) of the women (Figure 5.8). Assessment of the client medical history for risk status relevant to different methods of family planning was also poor. Almost none of the observed clients (1 percent) were asked about smoking, and less than half were asked about symptoms of STIs (43 percent) or chronic illnesses (47 percent). Traditionally smoking has not been common for women in Egypt, so assessment may not have been previously stressed. Recent information, however, suggests an increase in young women in Egypt who smoke, so assessment of smoking is of increasing relevance (MOHP, 1998; Global Youth Tobacco Survey Collaboration Group, 2001).

Finally, an assessment of the husband's attitude toward family planning or factors related to the husband that might affect the risk for STIs or method choice occurred for only 14 percent of the consultations for observed first-visit clients (Appendix Table A-5.26). Condom use was discussed with none of the clients.

Use of visual aids during the consultation was rare; however, visual aids were used twice as often for first-visit clients (14 percent) than for all clients (7 percent) (Appendix Tables A-5.24 and A-5.26).

Figure 5.8 Observed elements of client history for first-visit family planning clients (N=593)



Key Findings

Counseling for family planning clients is conducted under conditions that provide both visual and auditory privacy in 74 percent of facilities. Both counseling conditions and assurance of confidentiality (20 percent) have improved since 2002.

Assessment of relevant client history that might influence whether a family planning method is appropriate is not thorough, with around half or fewer first-visit clients assessed for current pregnancy or breastfeeding status, chronic illnesses, or symptoms of STIs. Almost no client was asked about smoking as a risk factor.

Visual aids are rarely used during counseling (7 percent of all clients).

5.5.3 Method-Specific Assessments and Examinations

First-visit clients usually receive a more complete examination than continuing clients, since examination findings help determine the appropriateness of a method. Among all first-visit clients, 65 percent had their blood pressure measured, 49 percent had their weight measured, 3 percent had their urine checked (usually for pregnancy), and 2 percent had a blood specimen taken (Appendix Table A-5.25).

Among all clients receiving methods with estrogen, where monitoring for hypertension should be a component of care, 66 percent had their blood pressure measured,[5] and 51 percent had their weight measured (gaining weight may be an indicator of fluid retention and hypertension) (Appendix Table A-5.27).

MOHP is promoting breast examinations as an early detection and prevention measure for breast cancer. Among all observed clients, none received a breast examination, and only 6 percent were taught how to conduct breast self-examination (Appendix Table A-5.28).

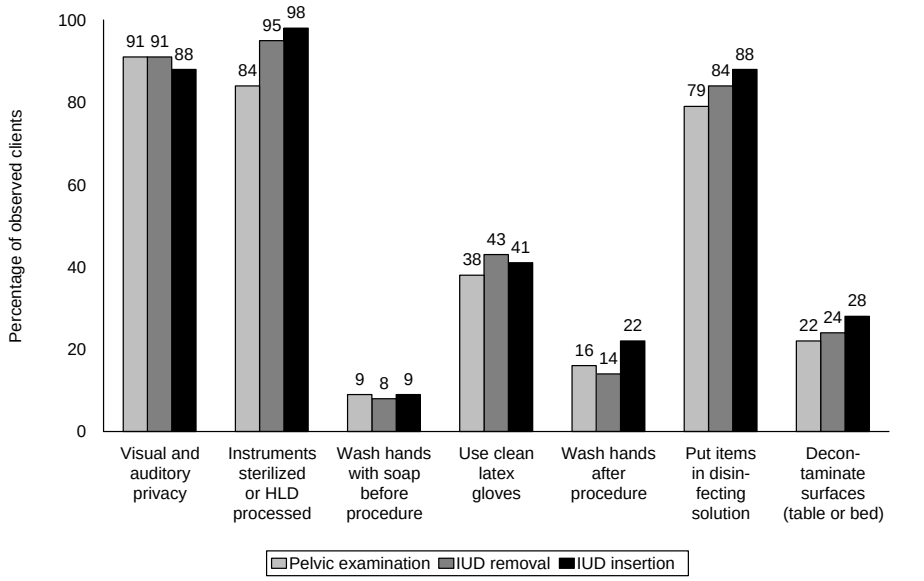
When clients received specific procedures, the observers noted whether critical information was shared, whether the procedure followed defined steps for quality, and whether infection control practices were followed.

Among the women who received pelvic examinations or IUD procedures, almost all (around nine in ten observed procedures) were conducted under conditions of both visual and auditory privacy (Figure 5.9). Sterilized or HLD-processed instruments were almost always used (84 percent for pelvic examinations and 98 percent for IUD insertion). Around one in ten providers washed their hands before the procedure, and two in ten washed their hands after the procedure. Latex gloves were used for only four in ten procedures. As mentioned previously, use of disposable gloves was universal, but these disposable gloves are nonlatex, thin, and easily torn, and are not defined by the ESPA 2004 as sufficient for infection control. Immediately placing items in disinfecting solution was a common practice (for around eight to nine in ten procedures); however, decontaminating the table or bed after the procedure was rare (about 25 percent).

As mentioned previously, it is uncertain if use of latex gloves during these procedures has decreased (around 67 percent in 2002) or if the type of glove was more accurately assessed in 2004.

[5] If the client was observed in a facility where blood pressure is measured systematically prior to the consultation, the client was assumed to have HAD the blood pressure measured, even if this was not observed for the particular client.

Figure 5.9 Key components for pelvic examination (N=285), IUD insertion (N=384), and IUD removal without reinsertion (N=152)

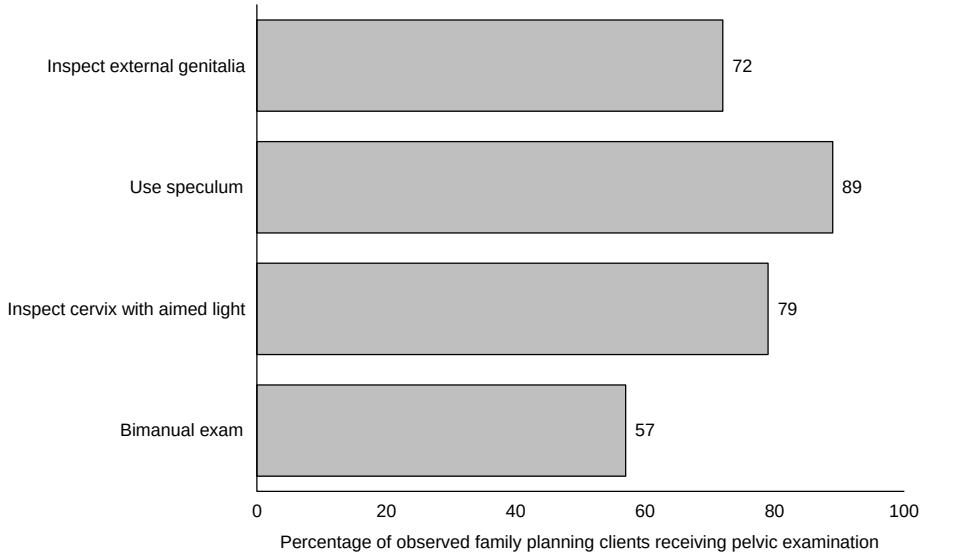


Egypt SPA 2004

Among the 14 observed implant insertion cases, the providers washed their hands before starting for 91 percent of cases, and sterile gloves were utilized in 61 percent of cases (data not shown).

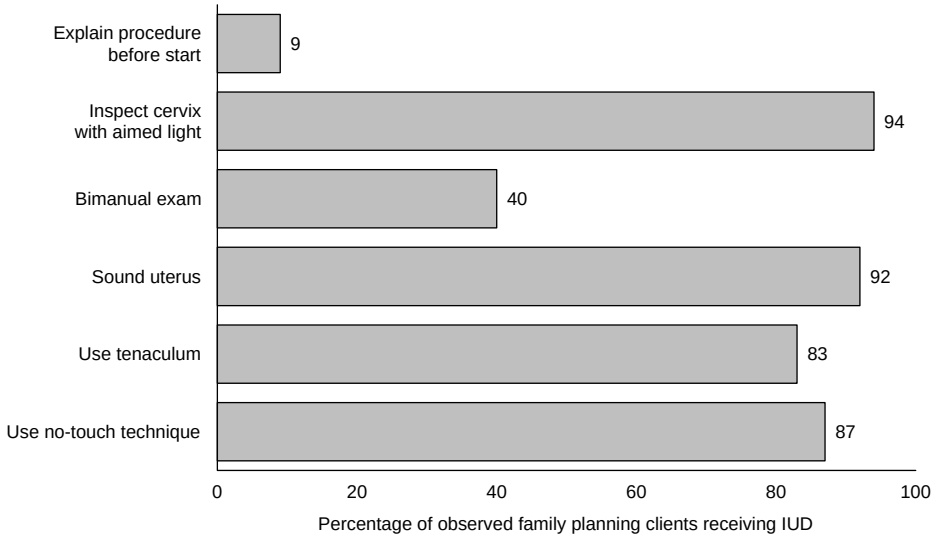
In general, providers did not explain procedures to the clients before starting procedures. Only 6 percent of clients receiving pelvic examinations (data not shown) and 9 percent of clients having IUD insertions were provided explanations before or during procedures. Seventy-nine percent of the pelvic examinations and 94 percent of IUD insertions included a visual inspection of the cervix (using a speculum and an aimed spotlight) (Figures 5.10 and 5.11, respectively). This is an improvement from 2002, when inspection of the cervix was observed for only 46 percent of women receiving IUDs. Bimanual examinations were conducted for 57 percent of women receiving pelvic examinations and 40 percent having IUD insertions, similar to findings in 2002. Among the observed IUD procedures, 92 percent sounded the uterus prior to insertion (a small increase over the 86 percent observed in 2002), 83 percent used a tenaculum, and 87 percent used the no-touch technique for handling the IUD (Figure 5.11).

Figure 5.10 Selected pelvic examination procedures observed (N=285)



Egypt SPA 2004

Figure 5.11 Selected IUD insertion procedures observed (N=384)



Egypt SPA 2004

All providers who were observed providing an injectable contraceptive were observed opening new needle and syringe packets, with 98 percent of these provided by the facility. Sharps containers were used to dispose of the used needles in 79 percent of the cases (data not shown) (a slight increase over 70 percent in 2002).

Key Findings

Adherence to standards for providing specific contraceptive methods safely is not consistent. Only two in three clients receiving estrogen-containing contraceptives have their blood pressure measured.

Explanations to the client about procedures and adherence to infection control measures (particularly hand-washing and use of latex gloves) are not common for pelvic and IUD procedures. Provider hand-washing prior to starting a procedure is rare (less than one in ten observed procedures).

New needles and syringes are used universally for injectable contraceptives.

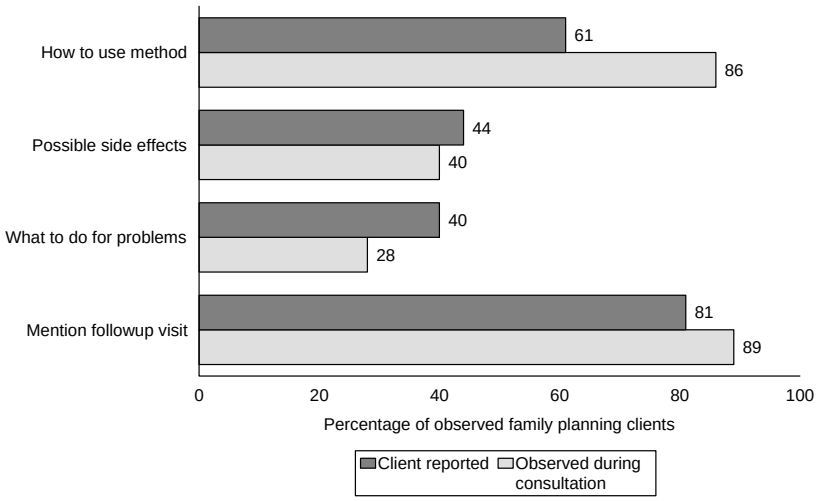
5.5.4 Counseling of Clients

Whether they are new contraceptive users or continuing users, certain information should be reviewed with clients during consultations. The provider should explain or review with the client how to use the method, its possible side effects, what to do for problems, and when the client should return for a followup visit.

Details on components of counseling that were observed and reported by the client are presented in Appendix Tables A-5.29 and A-5.30.

When clients were interviewed after the consultation, there was general consistency between what was observed during the consultation and what the client reported being told about the pill or injectable hormonal methods (Figure 5.12), with the exception of how to use the method. The reason why 25 percent of clients who were observed being told how to use the method reported that they were not told is uncertain. It is possible that they did not understand or were not paying attention. The difference in percentages between the observation and the client reports of counseling on side effects and problems may reflect the client's prior knowledge about the method and the provider's explanations during previous visits.

Figure 5.12 Information provided to hormonal method users, by client report and by observation (N=1,066)



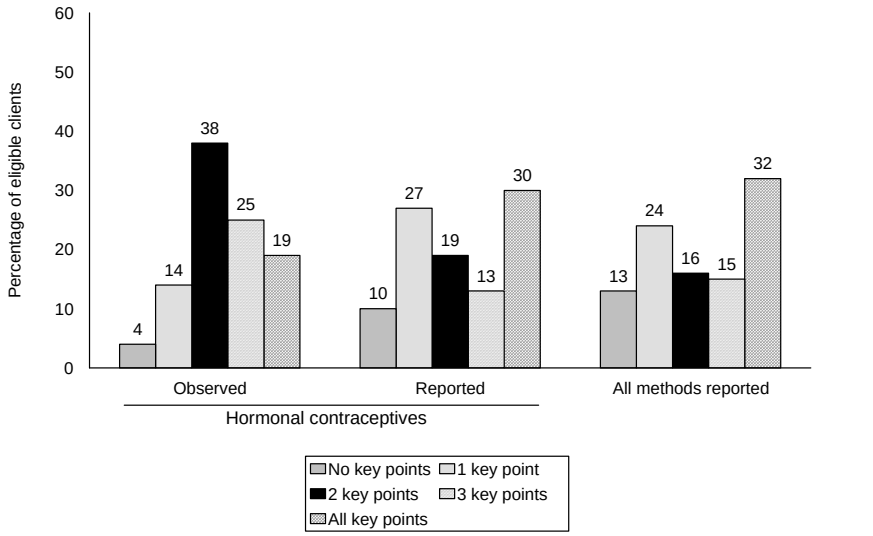
Egypt SPA 2004

Among the 665 women who received an IUD, only 40 percent were observed being instructed to check the string (an improvement from 31 percent in 2002), and 44 percent (39 percent in 2002) were observed being advised about possible heavy bleeding (Appendix Table A-5.30). Eighty percent of IUD users, however, reported that they knew how to check the string, indicating that many continuing clients had previously received this information.

Figure 5.13 shows that for 19 percent of observed clients using hormonal contraceptives (pills or injection), the provider was observed counseling on four key points for their method (how to use, possible side effects, what to do for problems, and time for followup visit). This is an improvement from 13 percent of observed clients using hormonal contraceptives whom the provider was observed counseling on four key points for their method in 2002. Reflecting the same trend, there were fewer consultations where no information on any of the key points was provided (4 percent in 2004 versus 9 percent in 2002).

Client exit interviews showed that about one in three clients who received a prescription or a method reported that they had received all four messages during the consultation, and only 13 percent reported that none of the essential information had been provided to them.

Figure 5.13 Number of key informational points discussed during consultations, by observation and by client report for oral and injectable hormonal contraceptive users (N=1,066), and by client report for all contraceptive method users (N=1,787)



Egypt SPA 2004

The percentage of interviewed clients using hormonal contraceptives who reported having been told none or one of the key informational points increased from 2002 (23 percent) to 2004 (37 percent), while the percentage of clients who reported receiving all key informational points decreased (41 percent in 2002 versus 30 percent in 2004). Although the actual observation supported an improvement in the quality of counseling based on the increased number of key informational points observed being provided to clients, its effectiveness is questionable; even immediately after the consultation, clients had difficulty recalling the key informational points pertaining to the methods they just received.

Although only one in three clients using hormonal contraceptive methods could recall all four key points discussed during the observed consultation, almost all (99 percent) (Appendix Table A-5.29) knew the critical information when asked about the contraceptive methods in use (98 percent in 2002), an

indication that the methods may have been discussed on multiple occasions during past visits. Nevertheless, MOHP might like to review the way in which the key informational points are delivered to family planning clients to improve retention. Even though clients may seem knowledgeable about their method, the provider should reinforce the key information at each visit.

Key Findings

Counseling on the four critical points for contraception (how to use contraceptive methods, what the side effects are, how to manage associated problems, and when a followup visit should occur) varied by type of method. Overall, one in three family planning clients reported that they were told all four messages for the method they received or were prescribed.

The consistency with which hormonal method users are being counseled on the four critical points has improved, with one in five clients observed being told all four messages and one in three reporting that they were told the four messages.

Client knowledge on how to use their method was good for most methods, indicating that, although counseling on use, side effects, and problem management may not have occurred on the day of the survey, it likely occurred during prior visits. The MOHP might like to review the way in which the key informational points are delivered to family planning clients to improve retention.

5.6 Client Opinions from Exit Interviews

After the observed consultation, the client was asked to participate in an exit interview during which her opinions on issues commonly related to client satisfaction were sought. Specifically, clients were asked if they had a problem with their method upon their arrival at the facility and whether the provider discussed the problem with them. The client was first asked to identify issues without prompting. Then the client was asked to comment whether specific issues were a big problem, a small problem, or not a problem at all for them.

Details on client opinion are provided in Appendix Tables A-5.31 and A-5.32. Appendix Tables A-5.33 and A-5.34 provide information on the employment and educational backgrounds of the observed and interviewed clients.

Few issues were considered big problems. The areas identified as problems were a long waiting time to see the provider (5 percent). The lack of medicines or supplies, which was a problem in 2002 (6 percent), was a problem for 2 percent of interviewed clients in 2004, similar to the other client service issues (Appendix Table A-5.31).

Half of the interviewed clients (53 percent) indicated that the proximity of the facility was a factor in selecting the facility, and 33 percent said that they selected the facility because the service they needed was available (Appendix Table A-5.32). Clients agreed that other important considerations for choosing the facility were that they were treated well (25 percent), the physician was efficient (24 percent), the facility had a good reputation (18 percent), and a female physician was present (32 percent). The importance of a female physician has increased since 2002 when only 20 percent of interviewed clients said that this was a factor in choosing a facility for family planning services.