Chapter 5 Family Planning Services

5.1 Background

5.1.1 SPA Approach to Collection of Family Planning Service Information

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

- 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.

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.

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 methods (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 (e.g., equipment for client examinations, guidelines and protocols, trained staff, a service delivery setting that allows client privacy, and infection-control procedures); and
- Availability of other health services relevant for family planning clients. These include education and services for STIs and programs geared toward groups with special needs to improve access and appropriate utilization of family planning services.

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

1. What is the availability of family planning services at the health facilities surveyed in the RSPA?
2. To what extent do the facilities offering family planning services have the infrastructure, resources, and supportive management required to support quality services?
3. To what extent do facilities offer family planning services for special groups?

5.1.2 Family Planning Services in Rwanda

Family planning activities in Rwanda began in 1982. After the Cairo 1994 International Conference on Population and Development challenged developing countries to broaden their understanding of demographic policy and to integrate their family planning services into the wider framework of

reproductive health, Rwanda redefined its reproductive health policy to promote integration of family planning services into all health services in the country.

The results of the 2000 Rwanda DHS survey (EDSR-II) indicated the following:

- Among married women and those in union, 4 percent used a modern method of contraception, and 9 percent used a traditional method at the time of the survey.
- Almost all respondents (94 percent of women and 98 percent of men) know at least one modern method of contraception.
- Use of modern methods of contraception is limited (3 percent among rural women and 14 percent among urban women).
- Many couples would use modern methods if they were available and corresponded to their needs. According to the EDSR-II, more than one-third of the women in union had unmet needs with respect to family planning. Beyond this, about 53 percent of women in union who were not using a contraceptive method expressed their wish to use a method in the future.

Contraceptive prevalence in Rwanda, a measure of the effectiveness of family planning activities, is low. A qualitative study conducted early in 2002 throughout the country to evaluate the underlying causes and principal barriers to the utilization of family planning services indicated that the principal constraint to access to health services was lack of family planning information and counseling (MoH, 2002). The study also revealed the continuing influence of pronatalist feelings in the country.

The RSPA collected detailed information about family planning services at health facilities. This information will be useful for guiding the family planning program and will contribute to reducing current levels of unmet need for family planning.

5.2 Availability of Family Planning Services

Table 5.1 presents information on the availability of family planning services. Overall, 71 percent of facilities offered temporary clinical methods of contraception, and 24 percent offered counseling on the rhythm method. Six percent of facilities (all hospitals) provide permanent methods (male or female sterilization). The clinical methods were more often available in health centers and dispensaries (75 percent and 80 percent, respectively) than in hospitals (44 percent). It was noted previously that where hospitals and dispensaries are adjacent to one another, the outpatient services, such as family planning, are more often provided in the dispensary. Clinical methods were also more frequently found in public facilities than in GAHFs (86 percent compared with 42 percent).

Family planning services should be offered regularly so that clients can depend on services being available when needed, and on providers being available to answer questions or respond to concerns. The methods offered at the facility must be consistently available to ensure there is no gap in supply and no need to substitute methods less desirable to the client. Limited finances and resources frequently result in family planning services being offered only one or two days a week. Table 5.2 shows that temporary methods of family planning services are available one or two days a week at 34 percent of facilities offering family planning services and five or more days per week at 60 percent of facilities.

Methods of family planning differ in how they function, their effectiveness, their side effects, the ease with which they can be used, and in view of these issues, their acceptability and desirability to users. To meet the varying needs and demands for contraception, a variety of methods should be available. The RSPA obtained information on the methods of family planning most commonly offered at health facilities in Rwanda. These include permanent methods, temporary (modern clinical) methods, and natural methods. Although the RSPA assessed whether permanent methods of contraception (male or female

sterilization) were available, the focus was on the conditions under which temporary contraceptive methods were provided.

Table 5.1 Availability of family planning services

Percentage of facilities offering temporary clinical methods of contraception, percentage offering permanent methods of contraception, and percentage offering counseling on the rhythm method, by type of facility, operating authority, and province, Rwanda SPA 2001

Background characteristic	Percentage of facilities offering: Temporary clinical methods of contraception[1]	Permanent methods of contraception[2]	Rhythm method	Number of facilities
Type of facility				
Hospital	44	41	24	34
Health center	75	0	26	170
Dispensary	80	0	11	19
Operating authority				
Public	86	5	23	144
GAHF	42	9	27	79
Province				
Butare	55	0	10	26
Byumba	82	6	28	17
Cyangugu	68	21	12	14
Gikongoro	72	0	21	12
Gisenyi	71	0	38	21
Gitarama	75	8	40	27
Kibungo	67	0	19	19
Kibuye	76	25	52	16
Kigali City	71	0	9	17
Kigali Ngali	82	6	7	17
Ruhengeri	73	10	23	19
Umutara	61	6	27	17
Total	71	6	24	223

[1] Any of the following: contraceptive pills (combined or progesterone only), injections (combined or progesterone only), condoms (male or female), implants, IUD, or spermicide.
[2] Male or female sterilization

The most commonly offered temporary methods are as follows:

- Contraceptive pills (either combined estrogen/progesterone or only progesterone), both taken daily;
- Contraceptive injections (either progesterone only, taken every two to three months, or more recently, a combined injection, taken monthly);
- Condoms (male and, more recently, female); and
- Rhythm (natural method based on prediction of female ovulation).

Availability of other, less frequently offered methods was also assessed. These are intrauterine devices (IUDs), progesterone implants, spermicides, and diaphragms.

A facility that offers all methods, including sterilization, is best able to meet the needs of clients. However, some variation in the availability of methods at facilities is expected because of differences in the qualifications and training required for service providers and in the infrastructure required to provide

Table 5.2 Frequency of availability of temporary family planning services

Percentage of facilities offering temporary methods of family planning (FP) 1-2 days per week, and offered 5 or more days per week by type of facility, operating authority, and province, Rwanda SPA 2001

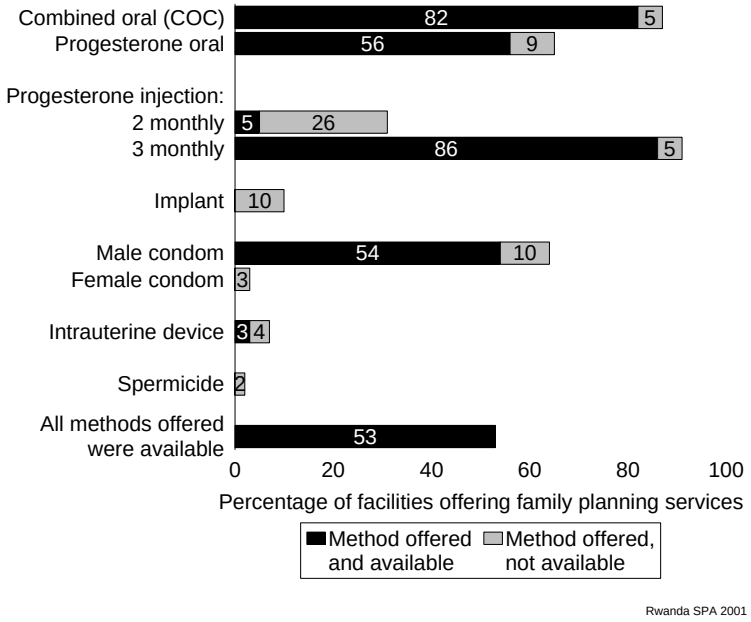
Background characteristic	Percentage of facilities offering temporary family planning methods		Number of facilities offering FP services
	1-2 days per week	5 or more days per week	
Type of facility			
Hospital	20	67	15
Health center	35	60	131
Dispensary	36	50	15
Operating authority			
Public	32	62	124
GAHF	40	53	37
Province			
Butare	53	42	16
Byumba	7	93	14
Cyangugu	34	43	11
Gikongoro	44	56	10
Gisenyi	37	63	15
Gitarama	41	54	20
Kibungo	33	61	13
Kibuye	68	16	12
Kigali City	28	62	12
Kigali Ngali	25	75	14
Ruhengeri	9	83	14
Umutara	23	66	10
Total	34	60	161

the methods safely. Commonly used methods that require minimal training to provide safely are pills, injections, and condoms. Implants and IUDs require a higher level of skill and a more developed infrastructure to administer safely. Among the facilities offering any family planning method, sterilization was the sole method available in 17 percent of the hospitals (2 percent of all family planning facilities) (Appendix Table A-5.1). As noted in Chapter 3, hospitals are often adjacent to dispensaries, and in these cases, the dispensary usually offers the outpatient services, such as temporary family planning methods, rather than the hospital. The rhythm method was the only method offered in 10 percent of the GAHFs (2 percent of all family planning facilities). At least two modern temporary methods were offered in 92 percent of all family planning facilities.

Figure 5.1 provides information on the percentage of facilities that offer each method and the percentage where the offered method was available on the day of the survey. Progesterone-only injections (every three months) and combined oral contraceptives are the methods of family planning most often offered—available at 91 percent and 87 percent, respectively, of facilities where family planning services are offered. Condoms are offered at only 64 percent of facilities, with little difference between type of facility or operating authority (Appendix Table A-5.1). IUDs, implants, female condoms (introduced as a trial in a few facilities), and spermicides are not widely available. The implant is offered primarily in hospitals (44 percent of those offering family planning services) and rarely in health centers or dispensaries (6 percent and 8 percent, respectively). The IUD is offered primarily at hospitals (33 percent) and at only 2 percent of health centers and 14 percent of dispensaries. These methods require special training and service delivery conditions to safely carry out required procedures. Although not widely available, they were offered more frequently in GAHFs than in public facilities. Implants and IUDs were available in 25

percent and 18 percent of GAHFs, respectively, compared with only 6 percent and 3 percent of public facilities. Female condoms are new in Rwanda and are available in only 3 percent of facilities. Spermicides are available in only 2 percent of facilities (health centers only). The diaphragm is not routinely used in Rwanda and availability was not assessed.

Figure 5.1 Method of contraception offered, and availability of method on the day of the survey (n=161)



Among facilities that offered family planning, almost all had pills and three-month injectables available on the day of the survey. The progesterone-only pill and the male condom were not available in about 10 percent of the facilities offering these methods. Implants and IUDs were lacking in most facilities that offer these methods. On the day of the survey, only 53 percent of facilities had all methods that they offered available. This was true in 54 percent of the public facilities and 49 percent of the GAHFs (data not shown). Similarly, only 80 percent of the dispensaries, 52 percent of the health centers, and 40 percent of the hospitals had all the methods they offer available on the day of the survey.

Key Findings

Modern, temporary methods of contraception are available in 86 percent of public facilities (71 percent of all facilities), but in only 42 percent of GAHFs.

The supply for offered methods is not reliable. Only 53 percent of facilities had all methods they offered on the day of the survey.

Variety of methods is lacking. Long-term methods, such as the IUD and implants, are rarely offered (7 percent and 10 percent of facilities, respectively), and few of the facilities offering these methods had them available the day of the survey.

Sterilization is available only in district hospitals, limiting client access.

5.3 Components Supporting Quality Family Planning Services

5.3.1 Infrastructure and Resources for Quality Counseling[1]

The RSPA assessed the availability of the following items for quality family planning counseling:

- Some level of auditory or visual privacy for counseling;
- Individual client health cards or records;
- Written guidelines or protocols; and
- Visual aids or written information for client education.

Family planning is often a sensitive issue for discussion. Assuring clients that conversation between client and provider cannot be overheard improves communication and, ultimately, the likelihood that the method provided is suitable for the client. It is not uncommon for family planning clients to be counseled in a room where other clients are waiting, but examinations and procedures requiring them to lie down or be exposed take place in a small adjacent room. Almost all facilities (93 percent) counseled family planning clients in either a private room or a room where there was a screen that could be drawn (Appendix Table A-5.2). Both of these situations were defined as providing some auditory privacy. Written family planning guidelines or protocols for family planning that included information on screening for eligibility of different methods were available in the family planning service delivery area in only 10 percent of facilities (Table 5.3), none of which were hospitals. Written guidelines or protocols

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

Percentage of facilities with protocols or guidelines for temporary family planning (FP) methods, percentage with visual aids, percentage with all items for infection prevention, percentage with all conditions for quality pelvic examinations, and percentage where treatment for sexually transmitted infections (STIs) is provided by FP service providers, by type of facility, operating authority, and province, Rwanda SPA 2001

Background characteristic	Percentage of facilities with:					Number of facilities offering FP services
	Items for counseling		All items for infection prevention[1]	Conditions for quality pelvic examination[2]	STI treatment provided by FP providers	
	Protocols or guidelines for FP	Visual aids				
Type of facility						
Hospital	0	53	47	33	40	15
Health center	11	49	36	17	45	131
Dispensary	13	70	37	13	49	15
Operating authority						
Public	11	51	34	20	47	124
GAHF	6	52	49	13	38	37
Province						
Butare	5	42	47	32	37	16
Byumba	7	66	21	11	73	14
Cyangugu	0	23	63	27	37	11
Gikongoro	0	63	46	18	27	10
Gisenyi	10	17	8	8	56	15
Gitarama	16	36	37	10	37	20
Kibungo	6	89	11	6	50	13
Kibuye	8	74	42	27	16	12
Kigali City	28	69	69	56	69	12
Kigali Ngali	25	84	92	25	50	14
Ruhengeri	0	31	9	0	52	14
Umutara	11	34	11	11	32	10
Total	10	51	37	18	45	161

[1] Soap, water, clean gloves, disinfecting solution, and sharps box
[2] Visual privacy, examination bed, examination light, and speculum

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

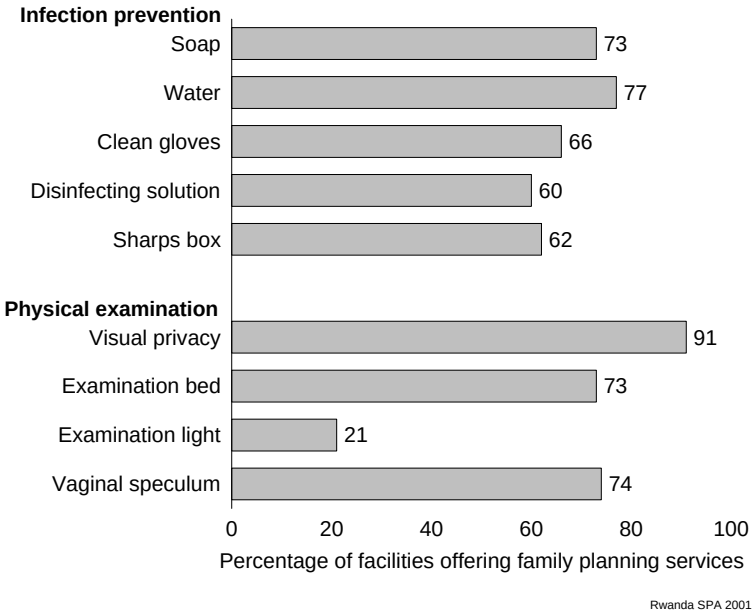
were more often available at public facilities (11 percent) than GAHFs (6 percent). Indivdual cards or records for family planning clients are important for monitoring clients over time, and for ensuring continuity of care. Because facilities often do not store client records, but rather, give them to the client to keep, the RSPA assessed the availability of blank cards for new family planning clients. Individual client cards were found at 79 percent of facilities (Appendix Table A-5.2) with availability similar across types of facilities and operating authority. Visual aids related to family planning were available in 51 percent of facilities. These were more often available at dispensaries (70 percent) than at other facilities (where around half had visual aids). Findings were similar for public facilities and GAHFs. All conditions for quality counseling were available in only 4 percent of facilities (Appendix Table A-5.2); written protocols or guidelines were the items most commonly missing.

The RSPA assessed the presence of items for infection prevention in the area where family planning examinations, such as pelvic examinations, took place. All items for infection prevention (hand-washing supplies, clean gloves, disinfectant solution, and a sharps box) were available in around one-third of the facilities (37 percent) (Table 5.3). Hospitals were more likely to have all items (47 percent) than health centers or dispensaries (36 percent and 37 percent, respectively). A higher proportion of GAHFs than public facilities had all items for infection prevention (49 percent compared with 34 percent). (However, individual items for infection prevention were missing in over one-fifth of facilities [Figure 5.2].)

Family planning clients frequently require a pelvic examination. Although most facilities had visual privacy (91 percent), only 73 percent had an examination bed, and few (21 percent) had a lighting source sufficient for good visualization during a pelvic examination. All conditions supportive of a quality pelvic examinations (visual privacy, an examination bed, an examination light, and a speculum) were available in only 18 percent of the facilities, and all infection prevention items were available in only 37 percent of facilities (Table 5.3).

Hospitals were more likely to have both all infection prevention and all examination infrastructure and materials (33 percent) than health centers (13 percent) or dispensaries (7 percent) (Appendix Table A-5.2).

Figure 5.2 Conditions for quality examination of family planning clients (N=161)



Key Findings

Almost all (93 percent) facilities offer family planning counseling and examinations under conditions that allow privacy.

Visual aids were available in the family planning service delivery area in more than half of facilities.

Written guidelines and protocols were rarely available (10 percent) in the family planning service delivery area.

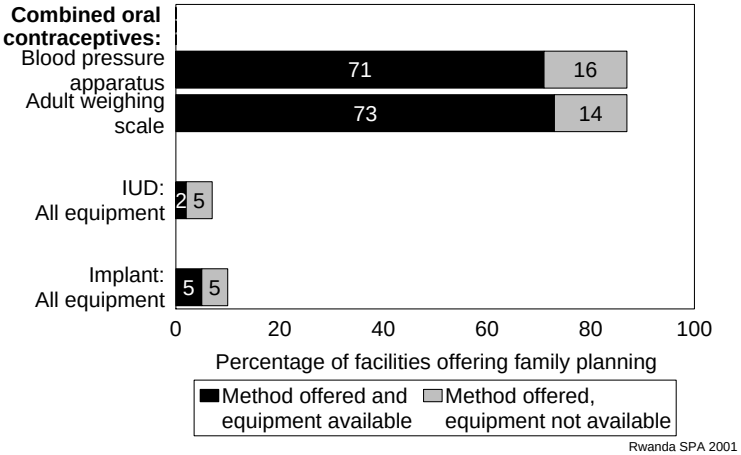
Facilities rarely had all items for infection prevention (37 percent) in the service area where family planning clients are examined.

All furnishings and equipment for pelvic examinations were available in only 18 percent of facilities. The item least likely to be available was an examination light. Although overall levels were low, public facilities were better equipped for pelvic examinations (21 percent) than GAHFs (13 percent).

5.3.2 Equipment and Resources for Quality Family Planning Services

Different contraceptive methods require different equipment to monitor the client and to provide the method safely. Safe provision of contraceptive methods that contain estrogen requires monitoring blood pressure, with some standards including weight monitoring. Although 87 percent of facilities offered the combined oral contraceptive with estrogen, blood pressure apparatus was available in only 71 percent of facilities (Figure 5.3). Likewise, a weighing scale was available in only 73 percent of facilities. Seven percent of facilities offer the IUD, but only 2 percent had the equipment (tenaculum and uterine sound, and a forcep for holding gauze to clean the cervix) for insertion of an IUD. Similarly, although 10 percent of facilities offered implant methods, only 5 percent had the trochar and canula, forceps, scissors, sterile gloves, and local anesthetic required for insertion or removal.

Figure 5.3 Percentage of facilities offering family planning that have equipment relevant to safe provision of combined oral contraceptives, IUDs, and implants available (N=161)



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 constitute essential components of quality family planning care. If these services are performed 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 STI if needed. Treatment of STIs by family planning providers, where they can diagnose and prescribe treatment for clients with symptoms without referring the client elsewhere, was available in 45 percent of facilities (Table 5.3). Integration of STI services with family planning was similar at all types of facilities, and slightly more common for public facility (47 percent) than GAHFs (38 percent).

Sixty-three percent of facilities had nystatin suppositories for treating candidiasis, a vaginal infection that can be sexually transmitted (Appendix Table A-5.3). Only 33 percent of facilities had medicines available to treat each of the main STIs: gonorrhea, chlamydia, trichomoniasis, and syphilis, with medicine for gonorrhea the most often lacking. STI medicines were more often found in hospitals (60 percent) than health centers (31 percent) or dispensaries (21 percent), and in GAHFs (47 percent) more often than public facilities (29 percent).

Key Findings

Blood pressure apparatus for monitoring clients receiving estrogen-based contraceptives are lacking in 13 percent of the family planning service delivery areas.

STI services are available in 45 percent of the family planning service areas.

Over 80 percent of family planning facilities had medicines for treating syphilis, chlamydia, and trichomoniasis.

Medicines for treating all of these STIs, plus gonorrhea, were lacking in 67 percent of facilities providing family planning services. GAHFs were better prepared to treat STIs, with 47 percent able to treat the four major STIs assessed, compared with 29 percent of public facilities.

5.3.3 Management Practices Supportive of Quality Services

Up-to-date registers for family planning services were defined as those having an entry in the past seven days that indicated the method used and whether the visit was a first-time or follow-up visit. These registers were available in 78 percent of facilities (Table 5.4). Hospitals were more likely to have up-to-date registers than other facilities (87 percent compared to around 78 percent).

Supportive management practices for family planning service providers were considered routine if at least half of the interviewed providers at a facility had received supervision or in-service education. Routine supervision of staff in a facility was identified for 77 percent of facilities, and routine in-service education during the previous 12 months was identified for 11 percent of facilities (Table 5.4). Overall, in only 10 percent of facilities had at least half of the staff both been supervised and received in-service education related to family planning. Higher proportions of public facilities routinely supervised their staff than GAHFs (82 percent compared with 60 percent). Routine provision of in-service education, however, was similar between public facilities and GAHFs.

Among the interviewed family planning service providers, 55 percent reported they were personally supervised during the preceding 6 months, 24 percent had received in-service training related to child health in the past 12 months, and 24 percent had received both types of supportive management (Appendix Table A-5.4).

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 at least half of the interviewed providers of FP services were personally supervised during the prior 6 months, received related in-service education during the prior 12 months, and were both supervised in the prior 6 months and received in-service training related to FP services during the prior 12 months and percentage where there are charges for services, by type of facility, operating authority, and province, Rwanda SPA 2001

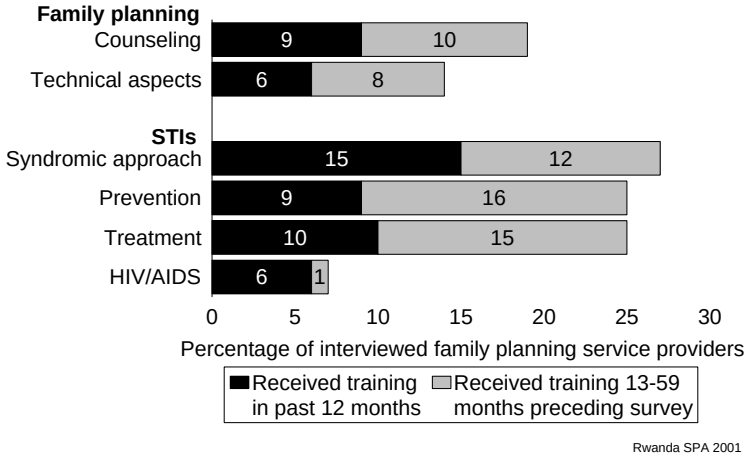
	Among facilities offering family planning services,					
		Percentage where at least half of the interviewed family planning service providers:				
Background characteristic	Percentage with up-to-date register[1]	Were personally supervised in past 6 months	Received in-service education in past 12 months	Were both personally supervised in past 6 months and received in-service education in past 12 months	Percentage with routine charges for FP services[2]	Number of facilities offering FP services
Type of facility						
Hospital	87	40	13	7	53	15
Health center	77	82	11	10	52	131
Dispensary	78	72	10	10	67	15
Operating authority						
Public	78	82	12	10	55	124
GAHF	80	60	11	8	47	37
Province						
Butare	74	82	12	6	42	16
Byumba	86	81	0	0	80	14
Cyangugu	51	83	28	19	40	11
Gikongoro	74	44	0	0	65	10
Gisenyi	70	100	26	26	20	15
Gitarama	79	78	6	6	74	20
Kibungo	72	100	33	33	22	13
Kibuye	84	68	0	0	34	12
Kigali City	81	69	0	0	91	12
Kigali Ngali	92	42	0	0	50	14
Ruhengeri	83	76	26	17	76	14
Umutara	89	90	0	0	45	10
Total	78	77	11	10	53	161

[1] Register indicates method and whether client is first-time or follow-up client
[2] Facility either has a charge or asks for donations for family planning services

In-service education related to family planning includes in-service education on aspects of prevention, diagnosis, or treatment of STIs. In-service education was similar for all types of facilities. GAHF providers had received recent in-service education more frequently than public facility providers (34 percent compared with 21 percent). It should be noted that 24 of the interviewed providers said they provided family planning services but worked in facilities that did not officially offer family planning services.

The in-service education topics on family planning covered most frequently in the 12 months preceding the survey were on STIs. Fifteen percent had received education on the syndromic approach to diagnosis and treatment of STIs. Figure 5.4 provides information on the specific topics of in-service education received most recently during the 12 months preceding the survey and in the 13-59 months preceding the survey.

Figure 5.4 In-service education received by interviewed family planning service providers, by topic and timing of most recent education (N=408)



User fees may provide additional funds to improve services, or they may act as a deterrent to client utilization. Fifty-three percent of facilities reported they either have a routine charge or ask for a donation toward some aspect of family planning services (Table 5.4). Dispensaries (67 percent) were more likely than hospitals (53 percent) and health centers (52 percent) to have a charge. Public facilities were more likely than GAHFs to charge (55 percent compared with 47 percent). Thirty-two percent of facilities had a charge for the consultation, with the median fee being 100 RFR. Median fees for various aspects of family planning services are provided in Appendix Table A-5.5.

Key Findings

Only a small proportion of family planning providers had received in-service education on topics specific to family planning methods (6 percent) or counseling (9 percent) during the 12 months preceding the survey.

In-service education on subjects related to STIs was received by a higher proportion of providers, with the most reported topic being the syndromic approach to STIs (15 percent).

5.4 Family Planning Programs for Special Groups

It is widely recognized that certain population groups require special attention to ensure access to family planning information and services and to increase appropriate client utilization. Groups often identified as requiring particular attention include adolescents, single mothers, and men.

Thirty-seven percent of facilities reported having special family planning service activities directed toward single mothers, 28 percent toward men, and 18 percent toward adolescents (Table 5.5). Public facilities were more likely (20 percent) to have special programs for adolescents than GAHFs (14 percent). The reverse is true with respect to single mothers and men, with GAHFs likely than public facilities to report special activities for single mothers (41 percent compared with 36 percent) and for men (33 percent compared with 27 percent).

Table 5.5 Family planning activities targeted toward special groups

Percentage of facilities with family planning (FP) activities that target adolescents, single mothers, and men, by type of facility, operating authority, and province, Rwanda SPA 2001

Background characteristic	Percentage of facilities with family planning activities for:			Number of facilities offering FP services
	Adolescents	Single mothers	Men	
Type of facility				
Hospital	7	47	40	15
Health center	20	37	27	131
Dispensary	19	32	24	15
Operating authority				
Public	20	36	27	124
GAHF	14	41	33	37
Province				
Butare	0	16	5	16
Byumba	21	48	41	14
Cyangugu	13	5	30	11
Gikongoro	9	19	0	10
Gisenyi	20	44	24	15
Gitarama	10	52	26	20
Kibungo	22	67	50	13
Kibuye	0	50	34	12
Kigali City	59	50	50	12
Kigali Ngali	17	25	17	14
Ruhengeri	9	16	24	14
Umutara	56	44	44	10
Total	18	37	28	161

Key Findings

Programs to meet family planning needs of special groups exist in some facilities and are more available in GAHFs than public facilities.

Around one-third of facilities have programs that focus on family planning issues for men (28 percent) or single mothers (37 percent).

Almost one-fifth of facilities have programs that focus on adolescents (18 percent).