



Contraceptive Security



Ministry of Health and Population
Contraceptive Security Project

Reasons of Shift from IUD to Oral Contraceptives among MOHP Clients 2007-2012

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December, 2012

Acknowledgement

MOHP succeeded in leading the family planning program in Egypt. According to EDHS 2008, the public sector was the source of FP methods among 67% of IUD users and 25% of OC users, and MOHP and NPC service statistics supported such evidence. However, throughout the period 2007 – 2011 there were gradual changes in the pattern of the method mix among MOHP/ FP users Therefore MOHP/PS **SCSSP** had supported this study that provided key information for the reasons of marked shift towards OC use in MOHP/FP clinics. Such information could help decision makers in improving the efficiency and effectiveness of FP services.

I would like to express gratitude to Dr. Hussam El-Khateeb, the Head of the MOHP/PS for his continuous support to conduct the assessment study. My thanks extend also to Dr. Magda Hussin, the Director General of the Contraceptive Commodity Department.

My cordial thanks and appreciation to **Dr. Omayma Zakaria**, the Director of the Contraceptive Security Project for her incessant support and help that made the conduction of the study very interesting and attractive activity. Without the support of **Dr. Omayma**, this study could not be accomplished.

My thanks extend to **Mr. Ibrahim Zaki** – MIS Consultant - Contraceptive Security Project. His intelligent notes and comments were very valuable in data analysis and presentation.

Thanks are due to all the MOHP/PS staff members to whom I have great respect and love. They always cooperative and wholehearted in upgrading their performance based on scientific research findings.

My great appreciations to MOHP staff members in Cairo, Menofia, Sharkia, Fayoum and Beni-Suef who expressed enthusiasm and collaboration by providing essential information necessary for the study.

Finally I express my gratitude and appreciation to UNFPA staff members who financially support the contraceptive security project and the current study. They always respond to the national strategic programs to improve health of mothers and children in Egypt.

Prof. Madiha Said

TABLE OF CONTENTS

	Page
Acknowledgement.....	I
List of Abbreviation	III
List of Tables	IV
List of Figures.....	V
EXECUTIVE SUMMARY	VI
CHAPTER 1: INTRODUCTION AND BACKGROUND	1
CHAPTER 2: GOAL AND OBJECTIVES	
2.1 Goal	3
2.2 Aim of the Study	3
2.3 Specific Objectives	3
CHAPTER 3 : METHODS	
3.1 Study Design	4
3.2 Study Setting	4
3.3 Sample Size and Sampling Technique	4
3.4 Data Collection	6
3.5 Data Quality Check	6
3.6 Data Analysis Plan	6
3.7 Ethical Considerations	7
3.8 Limitations of the Study	7
CHAPTER 4: RESULTS	
I- Quantitative Data (2007 -2011)	
[1] The observed increase in the proportion of OC clients in MOHP/PS Clinics	8
[2] Factors contributing for FP method shift towards OCs	10
[3] Acceptability of OC by users as expressed by respondents	23
[4] Leakage of OCs from MOHP FP-Clinics to other outlets!	27
[5] Causes of shift from IUD to OCs	28
[6] Capitalizing on physicians to increase IUD use	31
[7] Acceptability of having a role for trained nurse in IUD insertion	32
II- Qualitative Data (2012)	
■ The observed increase in proportion of OCs clients	39
■ Factors contributing for FP method shift towards OCs	39
■ Why clients prefer OCs?	40
■ Leakage of OCs from MOHP FP-clinics to other outlets	40
■ Causes of shift from IUD to OCs	41
■ Capitalizing on physicians to increase IUD use	41
■ Acceptability of having a role of trained nurse in IUD insertion	41
CHAPTER 5: CONCLUSION AND RECOMMENDATIONS.....	42
REFERENCES AND CITATIONS	44
ANNEX: Questionnaire Form.....	45

List of Abbreviation

AS	Acceptability Score
BBP	Basic Benefit Package
CAPMAS	Central Agency for Public Mobilization and Statistics
CBR:	Crude Birth Rate
CCM:	Current Contraceptive Methods
CCR:	Contraceptive Coverage Rate
CID:	Chemical Industries Development
COC:	Combined Oral Contraceptives
CPR:	Contraceptive Prevalence Rate
CS:	Contraceptive Security
CYP:	Couple Year Protection
EDHS:	Egypt Demographic and Health Survey
FDA:	Food and Drug Administration
FGD:	Focus Group Discussion
FHM:	Family Health Model
FP:	Family Planning
HQ:	Head Quarter
HSRP:	Health Sector Reform Program
FPDD	Family Planning District Director
FPDNS	Family Planning District Nurse Supervisor
IEC:	Information, Education and Communication
IUD:	Intra Uterine Contraceptive Device
OCs:	Oral Contraceptives
PHC:	Primary Health Care
PS:	Population Sector
MDGs	Millennium Development Goals
MIS	Management Information System
MOHP:	Ministry of Health and Population
MSI	Method Shift Index
MWRA	Married Women in the Reproductive Age
NCM:	New Contraceptive Methods
NGOs:	Non-Governmental Organizations
NPC:	National Population Council
NPP:	National Population Policy
SCSSP:	Supporting Contraceptive Security System Project
UFPA:	United Nations Fund for Population
WHO:	World Health Organization

LIST OF TABLES

Table (1)	Percent of MOHP- FP clients 2007 versus 2011 according to OCs and IUD users (MIS-MOHP/PS) and estimated Method Shift Index for SCSSP Governorates	5
Table (2)	Sample Size and Characteristics of Respondents distributed according to the Governorates included in the sample	5
Table (1.1)	Percent Distribution of the Respondents by Governorate, Current Job and duration of work in FP according to the observed increase in OCs clients	9
Table (2.1)	Acceptability score for the factors contributing to FP method shift towards OCs: service providers and outreach workers by Governorates	11
Table (2.2)	Acceptability score for the factors contributing to FP method shift towards OCs: FP operational policies and regulations, problems in management of resources by governorates	12
Table (2.3)	Acceptability score for the factors contributing to FP method shift towards OCs: service providers and outreach workers by Job of respondents	16
Table (2.4)	Acceptability score for the factors contributing to FP method shift towards OCs: FP operational policies and regulations, problems in management of resources by Job of respondents	16
Table (2.5)	Acceptability score for the factors contributing to FP method shift towards OCs: service providers and outreach workers by respondents' duration of work in FP services	20
Table (2.6)	Acceptability score for the factors contributing to FP method shift towards OCs: FP operational policies and regulations, problems in management of resources by respondents' duration of work in FP services	21
Table (3.1)	<i>Acceptability score for the reasons for Clients' Choice for OCs as Expressed by the Respondents by Governorates</i>	<i>23</i>
Table (3.2)	Acceptability score for the reasons for Clients' Choice for OCs as Expressed by the Respondents according to their current job.....	26
Table (3.3)	Acceptability score for the reasons for Clients' Choice for OCs as Expressed by the Respondents according to their duration of work in FP services	27
Table (4.1)	Acceptability score for the Respondents views towards leakage of OCs from MOHP- FP clinics to other places, by governorates	27
Table (4.2)	Acceptability score for the Respondents views towards leakage of OCs from MOHP- FP clinics to other places by current job of respondents in FP services	28
Table (4.3)	Acceptability score for the Respondents views towards leakage of OCs from MOHP- FP clinics to other places by duration of work in FP services	28
Table (5.1)	Acceptability score for the Respondents views towards causes of FP method shift from IUD to OCs by Governorates	29
Table (5.2)	Acceptability score for the Respondents views towards causes of FP method shift from IUD to OCs by current Job of Respondents	30
Table (5.3)	Acceptability score for the Respondents views towards causes of FP method shift from IUD to OCs by duration of work in FP Services	31
Table (6.1)	Acceptability score for the Respondents views towards intervention to promote the role of physicians in IUD insertion services by Governorates	31
Table (6.2)	Acceptability score for the Respondents views towards intervention to promote the role of physicians in IUD insertion services by current job of respondents	32
Table (6.3)	Acceptability score for the Respondents views towards intervention to promote the role of physicians in IUD insertion services by duration of work in FP services	32
Table (7.1)	Acceptability Scores for the requirements for eligibility of nurses for IUD insertion as expressed by the respondents by governorate	36
Table (7.2)	Acceptability Scores for the requirements for eligibility of nurses for IUD insertion as expressed by the respondents by current job	37
Table (7.3)	Acceptability Scores for the requirements for eligibility of nurses for IUD insertion as expressed by the respondents by duration of work in FP services	38

LIST OF FIGURES

Figure (1)	<i>Acceptability Score for Factors Contributing to shift from IUD use to OCs by rank ordering</i>	VII
Figure (1.1)	<i>Percent Distribution of Respondents according to acceptability of observed shift towards OCs in MOHP -FP Clinics</i>	8
Figure (2.1)	<i>Acceptability Score for Factors Contributing to shift from IUD use to OCs by rank ordering.....</i>	10
Figure (2.2)	<i>Percent Distribution of Respondents according to Acceptability that FP Clients Play a Major Role in the Observed Increase in OCs Use by Governorates.....</i>	11
Figure (2.3)	<i>Rank Ordering of Acceptability Scores for the Factors Contributing to Shift to OCS Use - Cairo Governorate</i>	13
Figure (2.4)	<i>Rank Ordering of Acceptability Scores for the Factors Contributing to Shift to OCs Use - Fayoum Governorate</i>	13
Figure (2.5)	<i>Rank Ordering of Acceptability Scores for the Factors Contributing to Shift to OCs Use – Menofia Governorate</i>	14
Figure (2.6)	<i>Rank Ordering of Acceptability Scores for the Factors Contributing to Shift to OCs Use – Beni-Suef Governorate</i>	14
Figure (2.7)	<i>Rank Ordering of Acceptability Scores for the Factors Contributing to Shift to OCS Use –Sharkia Governorate</i>	15
Figure (2.8)	<i>Percent Distribution of Respondents according toAcceptability that FP Clients Play a Major Role in the Observed Increase in OCs Use by Current Job</i>	15
Figure (2.9)	<i>Rank Ordering of Acceptability Scores for the Factors Contributing to Shift to OCS Use as expressed by FPDD</i>	17
Figure (2.10)	<i>Rank Ordering of Acceptability Scores for the Factors Contributing to Shift to OCS Use as expressed by FPDNS</i>	17
Figure (2.11)	<i>Rank Ordering of Acceptability Scores for the Factors Contributing to Shift to OCS Use as expressed by FP clinic male physicians</i>	18
Figure (2.12)	<i>Rank Ordering of Acceptability Scores for the Factors Contributing to Shift to OCS Use as expressed by FP clinic female physicians</i>	18
Figure (2.13)	<i>Rank Ordering of Acceptability Scores for the Factors Contributing to Shift to OCS Use as expressed by FP clinic nurses</i>	19
Figure (2.14)	<i>Percent Distribution of Respondents according to Acceptability that FP Clients Play a Major Role in the Observed Increase in OCs Use by duration of work in FP services.....</i>	19
Figure (2.15)	<i>Rank Ordering of Acceptability Scores for the Factors Contributing to Shift to OCs Use -by duration of work in FP: Less than 5 Years</i>	21
Figure (2.16)	<i>Rank Ordering of Acceptability Scores for the Factors Contributing to Shift to OCs Use -by duration of work in FP:5 -9 Years</i>	22
Figure (2.17)	<i>Rank Ordering of Acceptability Scores for the Factors Contributing to Shift to OCs Use -by duration of work in FP:10 Years and more</i>	22
Figure (3.1)	<i>Rank Ordering of Acceptability Score for the reasons for Clients' Choice for OCs as Expressed by the Respondents.....</i>	23
Figure (3.2)	<i>Acceptability score for the reasons for Clients' Choice for OCs as Expressed by the Respondents by Governorates: Cairo.....</i>	24
Figure (3.3)	<i>Acceptability score for the reasons for Clients' Choice for OCs as Expressed by the Respondents by Governorate: Fayoum</i>	24
Figure (3.4)	<i>Acceptability score for the reasons for Clients' Choice for OCs as Expressed by the Respondents by Governorate: Menofia</i>	25
Figure (3.5)	<i>Acceptability score for the reasons for Clients' Choice for OCs as Expressed by the Respondents by Governorate: Beni-Suef</i>	25
Figure (3.6)	<i>Acceptability score for the reasons for Clients' Choice for OCs as Expressed by the Respondents by Governorate: Sharkia</i>	26
Figure (5.1)	<i>Acceptability score for the Respondents views towards causes of FP method shift from IUD to OCs</i>	29
Figure (7.1)	<i>Percent Distribution of Respondents according to Acceptability that the nurse could provide IUD insertion services.....</i>	33
Figure (7.2)	<i>Percent Distribution of Respondents according to Acceptability that the trained nurse is eligible to insert IUD by governorate.....</i>	33
Figure (7.3)	<i>Percent Distribution of Respondents according to Acceptability that the trained nurse is eligible to insert IUD by current job of respondents.....</i>	34
Figure (7.4)	<i>Percent Distribution of Respondents according to Acceptability that the trained nurse is eligible to insert IUD by duration of work in FP services.....</i>	34
Figure (7.5)	<i>Acceptability Scores for the requirements for eligibility of nurses for IUD insertion as expressed by the respondents</i>	35
Figure (7.6)	<i>Acceptability Scores for the requirements for eligibility of nurses for IUD insertion as expressed by the respondents by governorate.....</i>	35
Figure (7.7)	<i>Acceptability Scores for the requirements for eligibility of nurses for IUD insertion as expressed by the respondents by current job.....</i>	37
Figure (7.8)	<i>Acceptability Scores for the requirements for eligibility of nurses for IUD insertion as expressed by the respondents by duration of work in FP services.....</i>	38

EXECUTIVE SUMMARY

There is evidence that the MDGs will not be achieved unless there is universal access to quality reproductive health services especially FP. Each country should address the different challenges to FP programs especially those related to unmet needs, discontinuation, and method mix to support the MDGs related to reducing maternal morbidity and mortality.

In Egypt, the contraceptive coverage rate had shown a decrease from 53.4% in 2007 to 45% in 2011. Additionally, the method mix had shown different profile in 2011 compared with that in 2007. According to MOHP/PS service statistics there was increase in FP clients by 39% in 2011 compared with 2007. However, the percent distribution of the clients according by method mix in 2007 was 29% for OCs, 20% for IUD and 51% for Injectables. The counterpart figures for year 2011 were 47% for OCs, 12% for IUD and 41% for Injectables. The shift from IUD as an *effective long-acting/ one-decision/lowest discontinuation rate FP method*, to OCs with highest discontinuation rate could have negative impact on family planning program in Egypt.

Those changes in method mix profile across time indicates changes in either/or the **demand and supply of FP methods**. Therefore, due to environment of change with multifactorial reasons of shift from IUD to OCs use, it was important to answer a research question: why there is marked method shift from IUD to OCs among MOHP/FP method user clients?

The **Goal** of the current study was improving the quality of life of Egyptian mothers and children through providing effective and safe family planning methods and services. **The objectives** were identification of the factors related to shift from IUD to OCs: the demand (clients' role), supply (availability) and or management of resources (training, supervision, incentives).

Methods: The study is health system-operations research. It is an exploratory study that has been conducted at the four levels of MOHP/PS- FP service delivery: Central (HQ), Governorate, District and service delivery points. The study included 5 out of total 10 MOHP/UNFPA-SCSSP governorates selected according to specific criteria as Egypt regional representation, percent increase in contraceptive method users (2007-2011) and FP method shift index. Therefore the study included Cairo, Sharkia, Menofia, Fayoum and Beni-Suef. The sample size of the respondents was 600 respondents from the selected governorates. Those respondents were FPDD, FPDND, physicians and nurses.

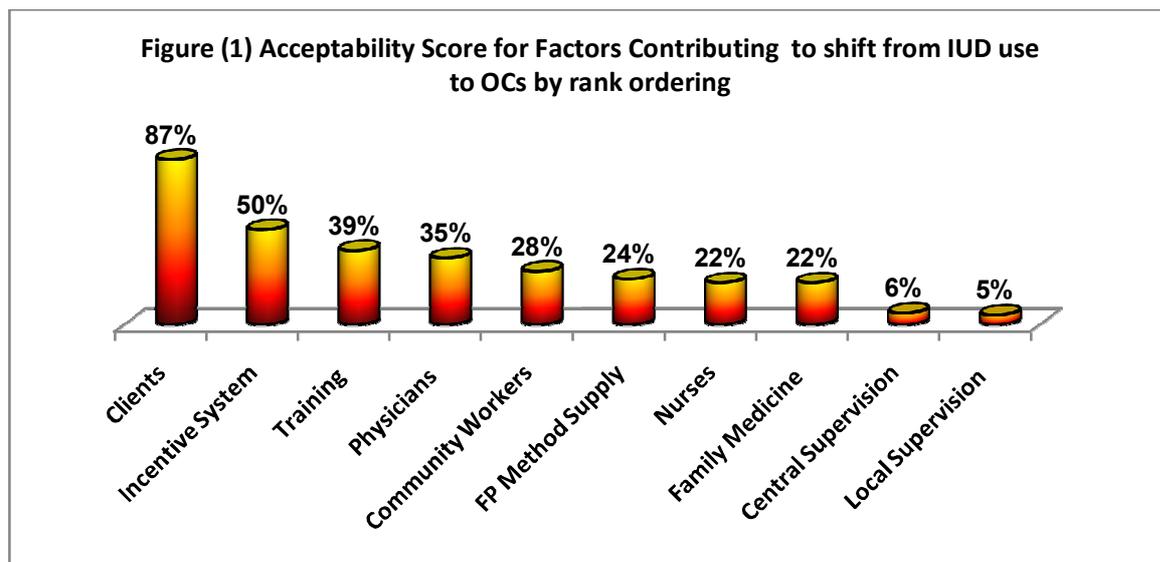
Data collection: both qualitative data (in-depth interviews with MOHP/HQ staff, FGDs with Health Directorates staff of the 5 governorates: FP director and Nurse Supervisors) and quantitative data (self-administered questionnaire to 600 respondents) were collected

Simple statistical methods had been used using independent variables as: governorates, current job of respondents and duration of work in FP. The dependent variables were causes of acceptability of OCs by clients and reduction in the percent of IUD clients. Chi square test of significance was used to assess the differences between the studied groups categorized according to the components of each independent variable. Acceptability Score (AS) had been estimated by using a single measure reflecting high acceptability level of respondents for

different statements. The views of the interviewed staff at the central and governorate level were used to provide explanation and interpretation to the quantitative data.

Results: The observation of increase in the proportion of OCs clients in MOHP/FP clinics was affirmed by the majority of respondents (94%).

The respondents AS regarding the ten variables that consider the demand and supply sides as well as management of resources that could influence FP method shift indicated that clients choice to OCs is the major cause of method shift (AS =87%), followed by lack of incentive (AS= 50%) and improper training of the service providers (39%) (Figure 1).



Factors contributing to FP method shift towards OCs related to service providers and outreach workers in relation to AS of respondents showed that Fayoum respondents had reported the highest AS (72%) for the role physicians in FP method shift towards OCs, versus AS of 29% in Cairo Governorate ($p=0.00$). Fayoum respondents had reported the highest AS (41%) for the role nurses in FP method shift towards OCs, versus AS of 16% in Cairo Governorate ($p=0.002$). Beni-Suef and Fayoum respondents had reported the highest AS (38%, and 37% for the two governorate respectively) for the role community workers in FP method shift towards OCs, versus AS of 25% in Sharkia Governorate ($p=0.00$).

Factors contributing to FP method shift towards OCs and related to elements of management of resources and AS of respondents showed that Beni-Suef respondents had reported the highest AS (64%) for the role of the incentive system in FP method shift towards OCs services, versus AS of 21% in Fayoum Governorate ($p=0.00$). Beni-Suef respondents had reported the highest AS (32%) for the role Family Medicine in FP method shift towards OCs services, versus AS of 13% for Sharkia Governorate respondents ($p=0.00$). Beni-Suef respondents had reported the highest AS (68%) for the role FP method supply in FP method shift towards OCs services, versus AS of 8% in Sharkia Governorate ($p=0.00$). Beni-Suef respondents had reported the

highest AS (48%) for the role of training system in FP method shift towards OCs services, versus AS of 26% for Cairo Governorate ($p=0.02$). Menofia respondents had reported the highest AS (17%) for the role of central supervision in FP method shift towards OCs services, versus AS of 1% in Sharkia Governorate ($p=0.00$). Menofia respondents had reported the highest AS (11%) for the role of local supervision in FP method shift towards OCs services, versus AS of 1% in Sharkia Governorate ($p=0.00$).

Information concerned with justification of respondents for mentioning that clients' role was pivotal in FP method shift towards OCs use indicated clients prefer OCs due to "autonomy of use /independent use" without needs of service providers (AS= 79%) followed by reasonable price of OCs (AS= 75%) and availability of the OCs at any time in MOHP clinics (AS =68%), and there is no need for gynecological procedures (AS= 66%).

AS of respondents regarding leakage of OCs outside FP clinics showed that eight percent of the respondents (AS=7%) affirmed the leakage of OCs from FP clinics. However, there were significant variations between respondents from different governorates regarding this issue. Beni-Suef respondents reported the highest AS (18%) for the observed leakage of OCs to pharmacies (AS=18%) and other places (AS=20%).

The respondents delineated that IUD insertion requires extra efforts from the physicians so as to get incentives per inserted IUDs (AS =64%). Such efforts extend beyond insertion to follow up services of IUD users (AS=51%).

The AS to the suggested arrangements to motivate physicians for providing IUD insertion services showed that a significant proportion of respondents from Menofia (93%) expressed acceptance of arrangement of submission of training certificate after insertion of 5 IUDs. However, 46% of respondents from Cairo had rejected this arrangement. Hundred percent of respondents from Sharkia had expressed acceptance of incentives in case of IUD insertion.

There was no consensus across the respondents assigned to different jobs in the hierarchy of FP services ($p < 0.05$) regarding the suggested training arrangement. A significant proportion of male physicians (90%) expressed acceptance of arrangement of training certificate after insertion of 5 IUDs versus (72%) of FPDD. Ninety nine percent of male physicians had expressed acceptance of incentives in case of IUD insertion, versus 94% of FP nurses.

Testing the acceptability of respondents towards involving nurses in IUD insertion, showed that 14% were highly accepting and 21% were just accepting this approach. There was significant variations across governorates ($P=0.00$) regarding acceptability that the trained nurse could be eligible for providing IUD insertion. While respondents from Beni-Suef demonstrated non acceptance for the eligibility of nurses to conduct IUD insertion (81%), 44% of respondents from Menofia had approved the idea that nurses could be eligible for providing IUD insertion services.

The highest objection rate was reported by male and female physicians (more than 70%) for the idea that the trained nurse is eligible to insert the IUD. However, there was statistically

insignificant variation across respondents with different jobs ($P=0.3$) regarding acceptability that the trained nurse could be eligible for providing IUD insertion.

Qualitative data showed that MOHP staff from the studied governorates highlighted the issue of true increase in the proportion of OCs clients in MOHP/FP clinics as recorded in the service statistics. However, MOHP Governorate staff considered that the indicator measuring their performance is the contraceptive coverage rate. This rate could be increased by increasing in OCs users when there are no enough IUD clients. One respondent from Sharkia Governorate claimed that the improvement in the quality of client's usage of OCs by being compliant for daily use resulted in increase in demands for OCs dispenses.

There was a consensus among participants that physicians become no more interested to upgrade their performance in IUD insertion and to carry the risk of IUD insertion, while, there is alternative way to provide the service of FP through dispensing OCs. This situation had made MOHP/FP clinics work as pharmacies for dispensing OCs, rather than providing quality FP services that are based on proper counseling, providing clinical examination and discussing the cafeteria of FP methods to clients, to build up the informed choice for FP methods. Respondents affirmed the role of training and incentive system in motivating physicians to provide quality FP services including IUD insertion.

The study concluded that there are three articulating issues that lead to shift from IUD to OCs: The unsatisfactory **training** and **incentive** systems for service providers and the **clients' choice** of OCs for independent use/autonomy without the need of provider's services.

CHAPTER 1: INTRODUCTION AND BACKGROUND

There is evidence that the MDGs will not be achieved unless there is universal access to quality reproductive health services. Therefore, new target has been added to MDGs in 2007 that emphasizes on the importance of family planning and increase in the contraceptive prevalence rate and reducing the unmet needs. Each country should address the different challenges to FP programs especially those related to unmet needs, discontinuation and method- mix to support the MDGs related to reducing maternal morbidity and mortality ⁽¹⁾.

In Egypt, the MOHP succeeded in leading the family planning program. MOHP reported success stories as a major source of contraceptive methods and quality services to different strata of the population. According to EDHS 2008⁽²⁾, the public sector was the source of FP methods among 67% of IUD users and 25% of OC users, and MOHP and NPC service statistics supported such evidence. According to NPC statistics ⁽³⁾, throughout the period 2007-2011 there was increase in the proportion of MWRA by 9.8%. The percent increase in the number of MOHP-FP clients who received FP methods had shown increase by 39% in 2011 compared with 2007 ⁽⁴⁾. The pharmacies had increased the amount of OCs available for users by 9% for the same reference period⁽³⁾. However, conferring to MOHP/PS statistics the method mix had shown different profile in 2011 compared with that in 2007⁽⁴⁾. The percent distribution of the clients according to the type of FP method in 2007 was 29% for OCs, 20% for IUD and 51% for Injectables. The counterpart figures for year 2011 were 47% for OCs, 12% for IUD and 41% for Injectables. Such findings designated that in 2007 for each 10 MOHP/FP clients 3 were using OCs, 2 were using IUD and 5 were using injections. However, there were marked shift towards OCs in 2011, as the corresponding figures were; for each 10 MOHP/FP clients 5 were using OCs, one was using IUD and 4 were using Injectables. There was variability across the Egypt Governorates regarding the change in the volume of FP-method clients in MOHP facilities as well as the changes in method mix across MOHP/FP clients.

The shift from IUD as an *effective long-acting/ one-decision/lowest discontinuation rate FP method*, to OCs with highest discontinuation rate could have negative impact on family planning program in Egypt. Additionally, the use of combined OCs could interfere with lactation with subsequent children morbidity and /or disconsolation of OCs and exposure to unwanted pregnancy.

The changes in method mix profile across time indicates changes in either/or both components related to the **demand for FP methods** as availability, accessibility, effectiveness and safety and acceptability (cultural, social, religious perceptions to FP, economic,) and the **supply of FP methods**(policies/regulations, availability of quality FP methods, and accessibility of quality

services, and availability of service providers, training, logistic management, time management/clients, supervision, incentive system, Family Medicine Model approach, integrated services and monitoring).

The study conducted by El-Zanaty& Associated (2008) ⁽⁵⁾ and Abdel-Razik et al, (2008) ⁽⁶⁾ provided evidence that family planning program in its transition phase from vertical to integrated program has reported shortage in FP specific activities as clinical supervision and on-job training. Service providers delineated that the newly supplied IUDs were not of adequate quality. There was marked reduction in the role of community workers due to involvement in different health activities in addition to FP. The provision of FP as free service compared to other FHM/BBP services- in the HSRP, reduced motivations to doctors and nurses to give priority to FP clients.

Due to environment of change with multifactorial reasons of shift from IUD to OCs use, it was important to answer a research question:why there is marked method shift from IUD to OCs among MOHP/FP Method user clients?

CHAPTER 2: GOAL AND OBJECTIVES

2.1 Goal

Improving the quality of life of Egyptian mothers and children through providing effective and safe family planning methods and services

2.2 Aim of the study

Identify the reasons of change in the FP method mix among MOHP/FP clients regarding shift from IUD to OCs with consideration to demand and supply components.

2.3 Specific Objectives

1. Assess the observation of FP directors and service providers to FP method shift from OCs to IUD,
2. Identify factors contributing to FP method shift towards OCs,
3. Provide explanation for the increased acceptability of clients to OCs, as viewed by FP service providers,
4. Investigate the false increase in OCs users due to leakage of OCs from MOHP to other places,
5. Recognize causes of shift from IUD use to OCs use in MOHP clinics,
6. Ascertain the motivating factors for physicians to provide quality IUD insertion services
7. Assess the acceptability of FP service providers towards involving the nurses in IUD insertion services

CHAPTER 3:METHODS

3.1 Study Design

The study is health system-operations research. It is an exploratory study that has been conducted at the four levels of MOHP/PS- FP service delivery: Central (HQ), Governorate, District and service delivery points. Service statics analysis will cover the national level data.

3.2 Study Setting

The study will be conducted in:

- MOHP/PS – HQ
- MOHP/PS –MIS
- NPC Statistics Department
- Cairo, Fyoun, Beni-Suef, Sharkia and Menofia Governorates

3.3 Sample Size and Sampling Technique

The selection of Governorates that had been included in the study had followed the criteria of inclusion:

- 1- Selecting five Governorates out of the ten SCSSP governorates
- 2- The geographical representation of Egypt regions
- 3- The percent increase in number MOHP/FP clients in 2011 compared to 2007
- 4- The Method Shift Index: the sum of (the percent changes in OC users in 2011 compared to 2007) and (percent changes in IUD users in 2011 compared to 2007)

MOHP/PS Supporting Contraceptive Security System Project (SCSSP) is working in tengovernorates: Two governorates in Lower Egypt: Menofia and Sharkia, Two Urban Governorates: Cairo and Alexandria and six Upper Egypt Governorates: Asuit, Beni-Suef, Fyoun, Mania, Quena and Souhag. Selection of the Governorates had been based on selecting two Lower Egypt Governorates, one Urban Governorate and two Upper Egypt Governorates. Since Menofia and Sharkia were the only two Lower Egypt Governorates both of them were included in the sample. For Urban governorates, table (1) showed negative FP – MSI for Alexandria governorate. Thus Alexandria Governorate was excluded from the sample, and Cairo was included. Out of the five Upper Egypt Governorates Fayoum and Beni-Suef were selected as they reported the lowest level of increase in the total FP users during the reference years 2011 compared to 2007.

Table (1) Percent of MOHP- FP clients 2007 versus 2011 according to OCs and IUD use (MIS-MOHP/PS) and estimated FP Method Shift Index for SCSSP Governorates

Governorates	% increase in total FP Method users Clients in 2011 versus 2007	Percent change in OCs users 2007-2011	Percent change in IUD users 2007-2011	FP Method Shift Index	Predicted Method Shift Index
Sharkia	80%	26%	-7%	19%	24
Menofia	49%	17%	-8%	9%	18
Cairo	6%	9%	-7%	2%	29
Alexandria	3%	8%	-10%	-2%	-63
Asuit	51%	18%	-8%	9%	18
Beni-Suef	34%	10%	-6%	5%	14
Fayoum	31%	11%	-7%	4%	12
Quena	34%	19%	-4%	15%	44
Menia	37%	15%	-5%	10%	27

From each selected governorate the sample size and categories of respondents were determined according to the number of districts within each governorate. Additionally the total sample of each governorate was determined according to the MSI. The two governorates which had highest MSI were Sharkia and Menofia. Therefore the total sample size was 150 respondents from each of both governorates. About 100 respondents had been selected from each of the other three governorates. The distribution of the different categories of the respondents by governorates was illustrated in table (2).

Table (2) Sample Size and Characteristics of Respondents distributed according to the Governorates included in the sample

Governorates	Method Shift Index	District Directors	Nurse Supervisors	Physicians	Nurses	Total
Cairo	2%	23	23	30	30	106
Fyoum	5%	7	7	40	40	94
Beni-Suef	4%	7	7	40	40	94
Sharkia	19%	13	13	65	65	156
Menofia	9%	10	10	65	65	150
Total		60	60	240	240	600

For the In-depth interview, the participants from the MOHP/PS HQ were representatives from contraceptive security, training, and field supervision departments. There were two FGDs, one for the five FP directors and one for the five nurse supervisors at the health directorate level in the studied Governorates.

All service statistics on contraceptive methods dispensed in Egypt 2007- 2011 and published by NPC and MOHP/PS had been considered in the study.

3.4 Data Collection:

■ Types and Sources of data

A- Quantitative data

The sources of the quantitative data were MOHP/PS MIS service statistics, NPC statistics, and self-administered questionnaire form to a sample of 600 respondents.

B- Qualitative Data

- In-Depth interview with MOHP/PS HQ staff members
- Focus Group Discussion with MOHP/PS FP directors in the five governorates
- Focus Group Discussion with MOHP/PS FP Nurse Supervisors in the five governorates

■ Instruments and Methods of Data Collection

- MIS spread sheets (excel) software material for FP service statistics for Egypt Governorates 2007 -2011
- Spread sheets for NPC statistics
- Guidelines for Focus Group Discussion and in-depth interviews will focus on:
 - (a) Demands for FP methods and reasons of change
 - (b) Supply for FP methods and reasons of change
 - (c) Changes in the process of FP service delivery at all levels
- The questionnaire form included questions related to:
 - The changing attitude of clients towards FP methods: causes and implications and impact on demand for specific methods
 - The changes in FP method supply and management of resources regarding policies , regulations, incentives supervision and training

3.5 Data Quality Check

The use of service statistics as a source of quantitative data indicates that all the target populations are included in the study without sampling. Therefore, there were no sampling errors. The format used by the MOHP/PS MIS and NPC which are used to issue the monthly and annual reports were used as a source of data for subsequent analysis to answer the research question.

Data quality check for the collected self-administered questionnaire formats had been office-reviewed and further revision had been done during data entry and preliminary analysis.

3.6 Data Analysis Plan

Both the quantitative and qualitative data were organized, articulated, analyzed and interpreted to answer the research question. The analysis will cover two major components related to FP methods:

Demand:

Availability, accessibility, effectiveness and safety and acceptability (cultural, social, religious perceptions to FP, economic,) and

Supply of FP methods:

Policies/regulations, availability of quality FP methods, and accessibility of quality services, and availability of service providers, training, logistic management, time management/clients,

supervision, incentive system, Family Medicine Model approach, integrated services and monitoring).

Simple statistical methods had been used using independent variables as: governorates, current job of respondents and duration of work in FP. The dependent variables were causes of acceptability of OCs by clients and reduction in the percent of IUD clients. Chi square test of significance was used to assess the differences between the studied groups categorized according to the components of each independent variable.

Acceptability Score had been estimated by using a single measure/ compound score formed of **Accepting= 1 and highly accepting = 2**. The acceptability score = [Sum of (number of respondents whose perspective to each statement as accepted * 1) and (number of respondents whose perspective to the statement as highly accepted * 2)] divided by Maximum high acceptability Score (i.e. total number of respondents to specific statement * 2) *100.

The views of the interviewed staff at the central and governorate level were used to provide explanation and interpretation to the quantitative data.

3.7 Ethical Considerations

There was an approval by the MOHP/PS Technical Committee to conduct the study. Qualitative data are collected after getting verbal consent from the participants. Analysis and presentation of quantitative data depend on already published data form MOHP, NPC and CAPMAS. For the questionnaire form, it will be anonymous and consent of participants had been obtained from the study participants.

3.8 Limitations of the Study

The perspectives of the FP users were not included in the study as it needs community –based study. Information related to the role of the pharmaceutical commercial sector in influencing the FP method mix is not directly obtained from pharmaceutical companies. However, the collected information included inquiries about leakage of OCs from MOHP clinics to other places including private pharmacies.

CHAPTER 4: RESULTS

The results of the study had been presented according to the following parameters:

- 1- The observed increase in proportion of OCs as perceived by study respondents
- 2- Factors contributing for FP method shift towards OCs
- 3- The current profile of acceptability of OCs by users as expressed by respondents
- 4- False increase in OCs users and leakage of OCs from MOHP FP-Clinics to other outlets,
- 5- Causes of shift from IUD to OCs
- 6- Capitalizing on physicians to increase IUD use
- 7- Acceptability of having a role of trained nurse in IUD insertion.

[1] The observed increase in Proportion of OCs Clients in MOHP/FP Clinics:

The observation of increase in the proportion of OCs clients in MOHP/FP clinics was affirmed by the majority of respondents (94%). The respondents who were FP directors and supervisors referred their observation to the complied service statistics at the district level and governorate level, as well as their role in setting and revising the request forms for the FP methods. The respondents who were service providers built their views on the observation that dispensing OCs to clients is increasing over time (Figure 1.1).

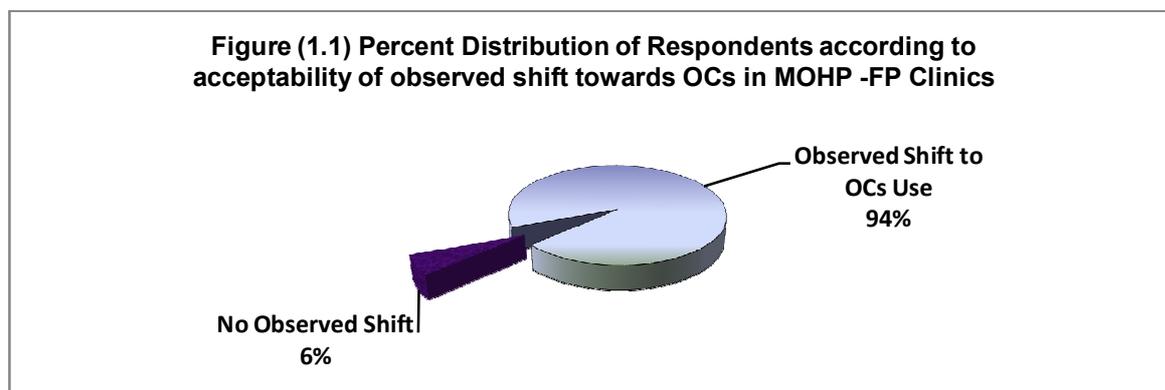


Figure (1.1) Percent Distribution of Respondents according to acceptability of observed shift towards OCs in MOHP -FP Clinics

The study respondents were categorized by Governorate, current job and duration of work in FP and analyzed according to the observation of increase in OCs clients (table 1.1). More than 90% of respondents in four governorates reported the observation of increase in OCs clients, except respondents from Beni-Suef Governorate where only 82% reported the observation of increase in OCs clients. The variation across governorate regarding the reported observation of increase in proportion of OCs clients was statistically significant ($p=0.000$). Rank ordering of the studied Governorates according to the proportion of respondents reported the observation of increase in OCs clients showed that Sharkia respondents ranked the first (99%) followed by Menofia (95%) and Cairo (95%), then Fayoum (93%) and Beni-Suef (82%). It is interesting to find that such rank ordering corresponded to the estimated MSI (Method Shift Index) for Sharkia (MSI= 19%) and Menofia (MSI= 9%).

The information pertaining to the association between the current job of the respondents and the reported observation of increase in the proportion of OCs clients was illustrated in table (1.1). As depicted from the table, FP directors and nurse supervisors had formed the highest percentage regarding the observation of increase in proportion of OCs clients (98%) followed by nurses of the clinics (94%) and then physicians of the clinics (92%). However, there was no statistically significant difference between the different respondents distributed by job and the percentage reported the observation investigated in the current study ($p=0.2$).

The duration of work in FP is one of the determinant factors for judging the changes in the pattern of FP clients regarding the method used. Therefore, table (1.1) considered this factor i.e. duration of work in FP and the observed increase in the proportion of OCs clients. It is obvious that more than 92% of respondents worked in FP services for one year and more had reported the observed increase in the proportion of OCs clients, versus (89%) of responded worked in FP services for a period less than one year. However, there was no statistically significant difference between the different respondents distributed by duration of work in FP and the percentage reported the observation of increase in the proportion of OCs clients ($p=0.3$).

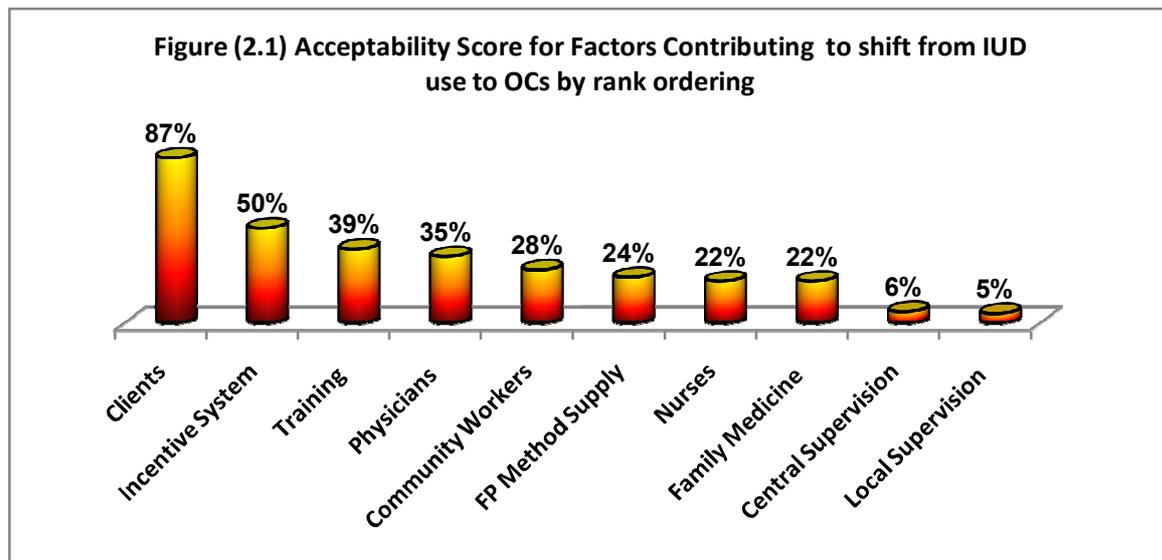
Table (1.1) Percent Distribution of the Respondents by Governorate, Current Job and duration of work in FP according to the observed increase in OCs clients

Characteristics	Observed increase in OC		No observed increase in		Total	
	No	%	No	%	No	%
Governorates*						
Cairo	97	95%	5	5%	102	17%
Fyoum	92	93%	7	7%	99	16%
Menofia	147	95%	8	5%	155	26%
Beni-Suef	84	82%	18	18%	102	17%
Sharkia	150	99%	1	1%	151	25%
Total	570	94%	37	6%	607	100%
Current Job of Respondents**						
FP District Director	57	98%	1	2%	58	10%
FP District Nurse	62	98%	1	2%	63	11%
Physician in Health Unit	65	92%	6	8%	71	12%
Physician in health Unit	144	92%	12	8%	156	27%
FP Nurse	207	94%	14	6%	221	39%
Total	535	94%	34	6%	569	100%
Duration of Work in FP Services***						
< One Year	56	89%	7	11%	63	11%
One- 4 Years	130	96%	5	4%	135	25%
5 -9 Years	124	94%	8	6%	132	24%
10- 19 Years	152	95%	8	5%	160	29%
20 Years and more	55	93%	4	7%	59	11%
Total	517	94%	32	6%	549	100%

* $p = 0.000$ ** $p = 0.2$ *** $p = 0.3$

[2] Factors contributing for FP method shift towards OCs

The study included ten variables that consider the demand and supply sides as well as management of resources that could influence FP method shift. The demand side was represented by “clients”. The supplyside was represented by: manpower (physicians, nurses and community workers) and FP method supply. The management of resources component was represented by: incentive system, training, family medicine, and supervision). Acceptability score (AS) which represent the average percent of respondents who were highly accepted a specific factor or statement. As observed from figure (2.1) the majority of respondents (AS =87%) pointed to the clients as the major factor determining the increase in OCs use. However, the client’s decision to use OCs rather than other FP method is the outcome of articulated experience regarding the other methods as well as the quality of service that she expect to receive when she select each method. Regarding the second factor for method shift towards OCs, the respondents considered the lack of incentive (AS= 50%) was a negative motivation for service providers to spend efforts to provide quality counseling to support informed choice for women, as well as to express the keenness to respond to women’s demand for methods other than OCs. The respondents considered that the training of service providers is not enough to provide good counseling and to provide skillful service as IUD insertion(AS = 39%). Therefore, dispensing OCs is easiest service for both providers and clients.



The perspectives of respondents, expressed as acceptability score, towards the factors contributing for FP method shift towards OCs were presented according to governorates in Figure (2.2), Tables (2.1 and 2.2). Figure (2.2) illustrates the perspectives of the respondents to the role of the client in FP method shift towards OCs across the five governorates. It is evident that there was a variation across governorates regarding acceptability of the role of the clients in FP method shift to OCs. Higher acceptability for this component was reported by Fayoum respondents (77%) versus the counterpart figure for Beni-Suef (53%). The observed variation regarding the level of acceptability that clients played the major role in method shift to OCs was statistically significant ($p = 0.001$).

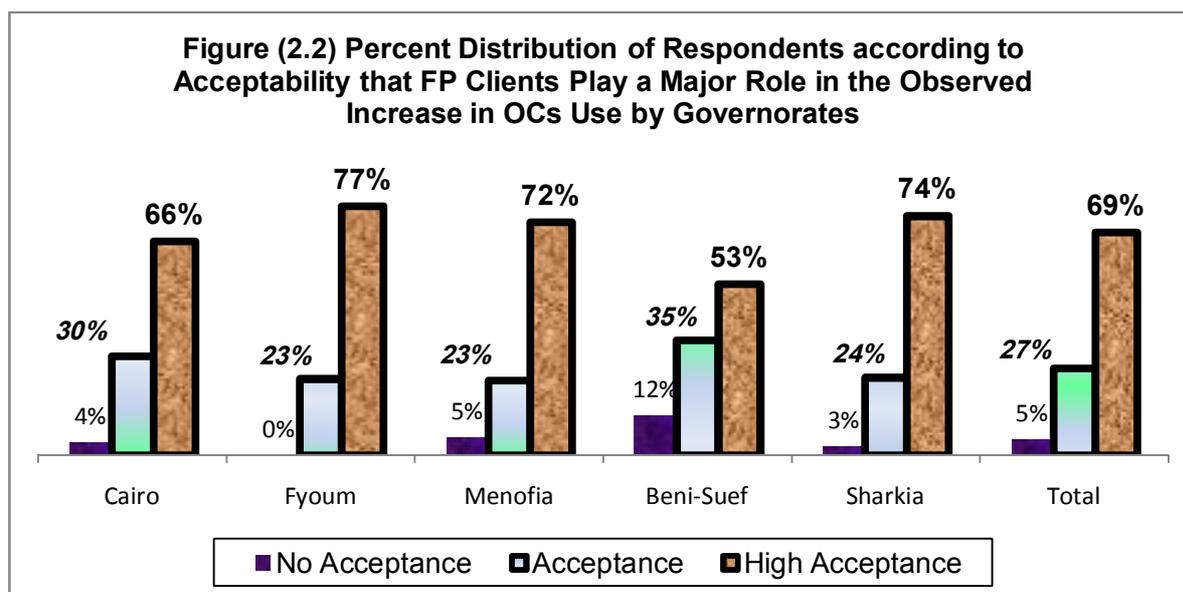


Figure (2.2) Percent Distribution of Respondents according to Acceptability that FP Clients Play a Major Role in the Observed Increase in OCs Use by Governorates

Factors contributing to FP method shift towards OCs related to service providers and outreach workers in relation to AS of respondents were illustrated by governorates in table (2.1). The table shows that Fayoum respondents had reported the highest AS (72%) for the role physicians in FP method shift towards OCs services, versus AS of 29% in Cairo Governorate ($p=0.00$). Fayoum respondents had reported the highest AS (41%) for the role nurses in FP method shift towards OCs services, versus AS of 16% in Cairo Governorate ($p=0.002$). Beni-Suef and Fayoum respondents had reported the highest AS (38%, and 37% for the two governorate respectively) for the role community workers in FP method shift towards OCs services, versus AS of 25% in Sharkia Governorate ($p=0.00$).

Table (2.1) Acceptability score for the factors contributing to FP method shift towards OCs: service providers and outreach workers by Governorates

Factors	Acceptability	Governorates					Total	P
		Cairo	Fyoun	Menofia	Beni-Suef	Sharkia		
Physicians	Acceptability Score	29%	72%	28%	40%	32%	35%	0.00
	% of Non-acceptors	60%	17%	63%	48%	56%	55%	
	Total	92	29	106	95	149	471	
Nurses	Acceptability Score	16%	41%	25%	29%	18%	22%	0.002
	% of Non-acceptors	77%	52%	67%	62%	76%	70%	
	Total	92	21	105	93	148	459	
Community Workers	Acceptability Score	12%	37%	35%	38%	25%	28%	0.00
	% of Non-acceptors	84%	58%	56%	53%	66%	64%	
	Total	91	19	108	94	149	461	

Factors contributing to FP method shift towards OCs related to elements of management of resources in relation to AS of respondents were illustrated by governorates in table (2.2). The table shows that Beni-Suef respondents had reported

the highest AS (64%) for the role of the incentive system in FP method shift towards OCs services, versus AS of 21% in Fayoum Governorate ($p=0.00$). Beni-Suef respondents had reported the highest AS (32%) for the role Family Medicine in FP method shift towards OCs services, versus AS of 13% for Sharkia Governorate respondents ($p=0.00$). Beni-Suef respondents had reported the highest AS (68%) for the role FP method supply in FP method shift towards OCs services, versus AS of 8% in Sharkia Governorate ($p=0.00$). Beni-Suef respondents had reported the highest AS (48%) for the role of training system in FP method shift towards OCs services, versus AS of 26% for Cairo Governorate ($p=0.02$). Menofia respondents had reported the highest AS (17%) for the role of central supervision in FP method shift towards OCs services, versus AS of 1% in Sharkia Governorate ($p=0.00$). Menofia respondents had reported the highest AS (11%) for the role of Local supervision in FP method shift towards OCs services, versus AS of 1% in Sharkia Governorate ($p=0.00$).

Table (2.2) Acceptability score for the factors contributing to FP method shift towards OCs: FP operational policies and regulations, problems in management of resources by governorates

Factors	Acceptability	Governorates					Total	P
		Cairo	Fyoum	Menofia	Beni-Suef	Sharkia		
Incentive System	Acceptability Score	49%	21%	34%	64%	57%	50%	0.00
	% of Non-acceptors	50%	71%	62%	32%	36%	46%	
	Total	92	14	120	97	148	471	
Family Medicine System	Acceptability Score	22%	18%	23%	32%	13%	22%	0.002
	% of Non-acceptors	73%	73%	72%	59%	81%	72%	
	Total	92	15	102	97	145	451	
Family Planning Method Supply	Acceptability Score	8%	31%	18%	68%	8%	24%	0.00
	% of Non-acceptors	89%	57%	79%	25%	90%	73%	
	Total	92	15	102	97	145	451	
Training System	Acceptability Score	26%	42%	44%	48%	38%	39%	0.02
	% of Non-acceptors	67%	50%	49%	44%	52%	52%	
	Total	91	16	111	96	150	464	
Central Supervision	Acceptability Score	3%	9%	17%	5%	1%	6%	0.00
	% of Non-acceptors	96%	87%	77%	94%	98%	92%	
	Total	92	15	102	97	150	456	
Local Supervision	Acceptability Score	2%	4%	11%	6%	1%	5%	0.00
	% of Non-acceptors	98%	93%	86%	92%	98%	94%	
	Total	92	15	100	91	150	448	

To set priorities for intervention to deal with the issue of FP method shift towards OCs, each governorate has to be considered a unit of analysis because of the noticed statistically significant difference between governorates regarding the views of respondents to the factors contributing to FP method shift. Figure (2.3) illustrates the situation in Cairo Governorate. The figure shows that the highest AS for the factors contributing for FP method shift to OCs was reported for clients (66%) followed by incentive system (49%) then physicians (29%) and training (26%).

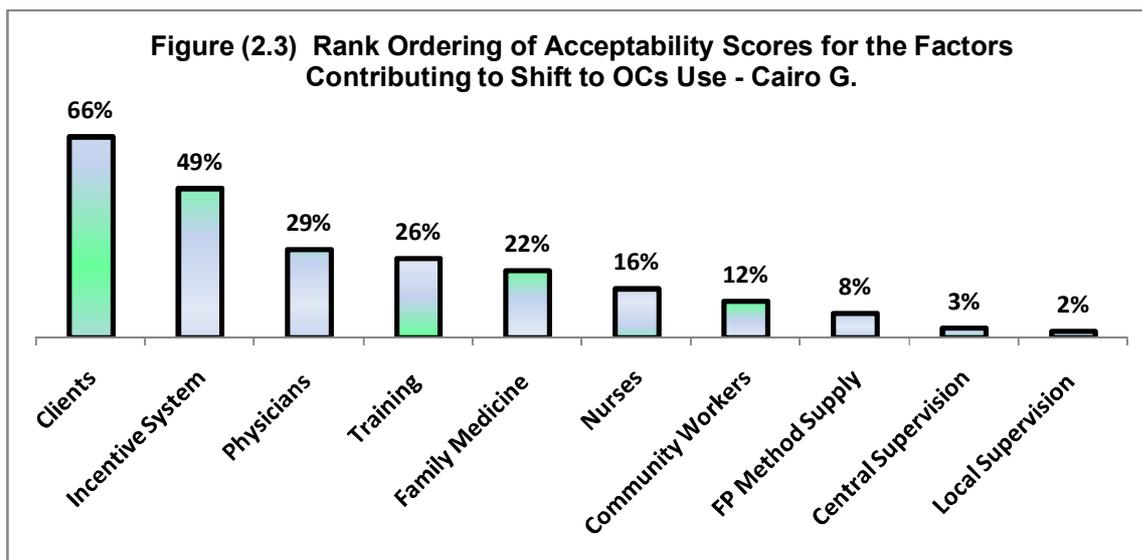


Figure (2.3) Rank Ordering of Acceptability Scores for the Factors Contributing to Shift to OC Use - Cairo Governorate

Figure (2.4) demonstrates the situation in Fayoum Governorate. As noticed from the figure Fayoum respondents had attributed the highest AS for the factors contributing for FP method shift to OCs to clients (77%) followed by service providers as physicians (72%) and nurses (41%).

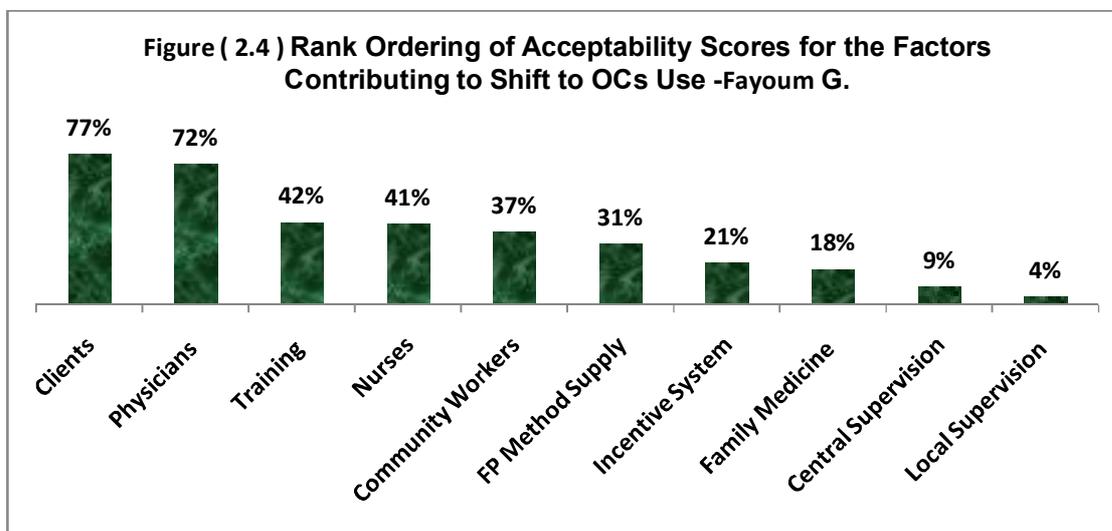


Figure (2.4) Rank Ordering of Acceptability Scores for the Factors Contributing to Shift to OC Use - Fayoum Governorate

Figure (2.5) presents the situation in Menofia Governorate. As noticed from the figure, Menofia respondents had ascribed the highest AS for the factors contributing for FP method shift to OCs to clients (72%) followed by management of the resources as training (44%), Outreach in FP (35%) and incentive system (34%).

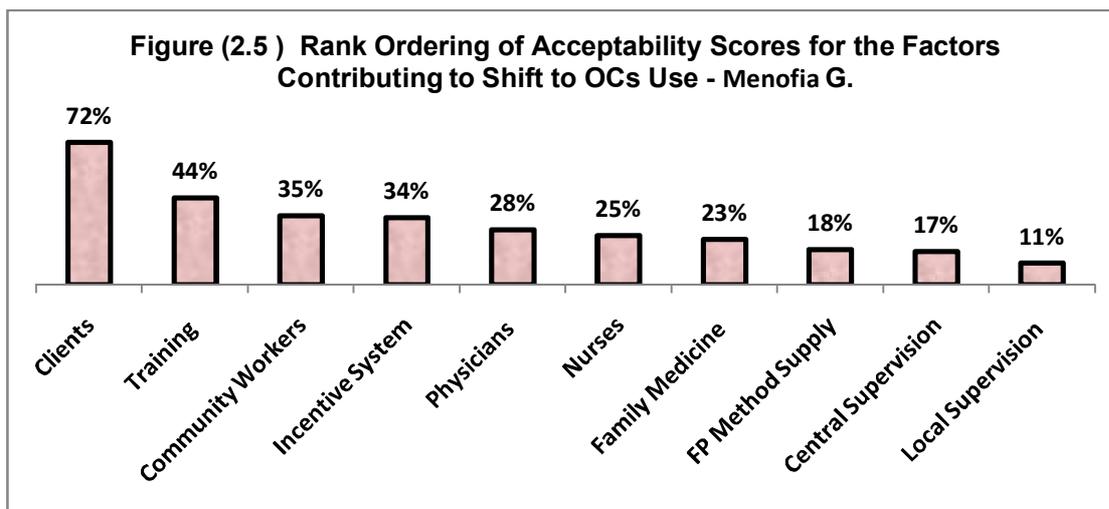


Figure (2.5) Rank Ordering of Acceptability Scores for the Factors Contributing to Shift to OC Use –Menofia Governorate

Figure (2.6) presents the situation in Beni-Suef Governorate. As remarked from the figure, Beni-Suef respondents had a unique view for the factors contributing for FP method shift to OCs. The respondents pointed to the FP system as the primary reason for shift towards OC. The method-mix quantitatively supplied for each method was the major deriving force for method shift towards OCs (AS = 68%). Incentive system ranked the second factor contributing to method shift (AS= 64%).

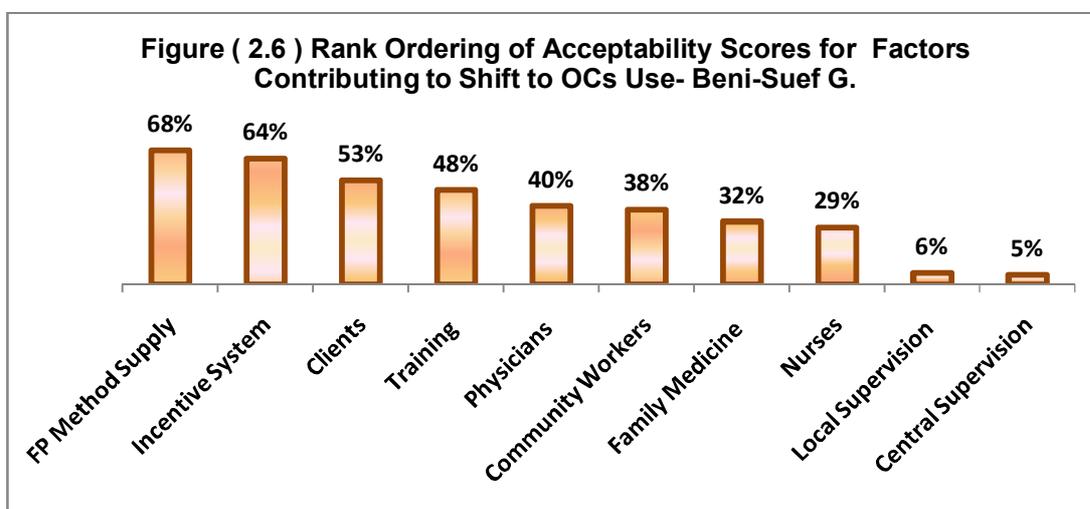


Figure (2.6) Rank Ordering of Acceptability Scores for the Factors Contributing to Shift to OC Use –Beni-Suef Governorate

Figure (2.7) demonstrates the situation in Sharkia Governorate. As noticed from the figure Sharkia respondents had attributed the highest AS for the factors contributing for FP method shift to OCs to clients (74%) followed by the improperly functioning two system i.e. Incentive System (AS = 57%) and Training System (AS= 38%).

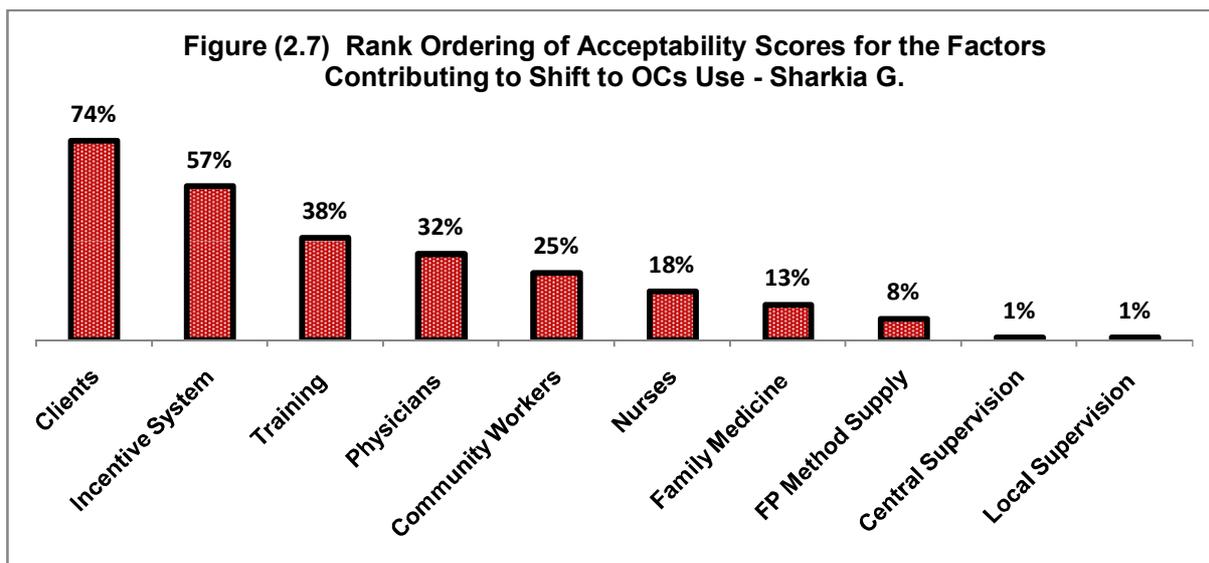


Figure (2.7) Rank Ordering of Acceptability Scores for the Factors Contributing to Shift to OC Use –Sharkia Governorate

The views of respondents towards the reasons of FP method shift towards OCs had been analyzed in relation to the current job of the respondents. Figure (2.8) presents the percent distribution of respondents according to acceptability that FP Clients play a major role in the observed increase in OCs use by current job. The figure highlights that nurses working in the family planning clinics represented the highest proportion (74%) reported high acceptability that clients constituting a powerful factor in method shift towards OCs.

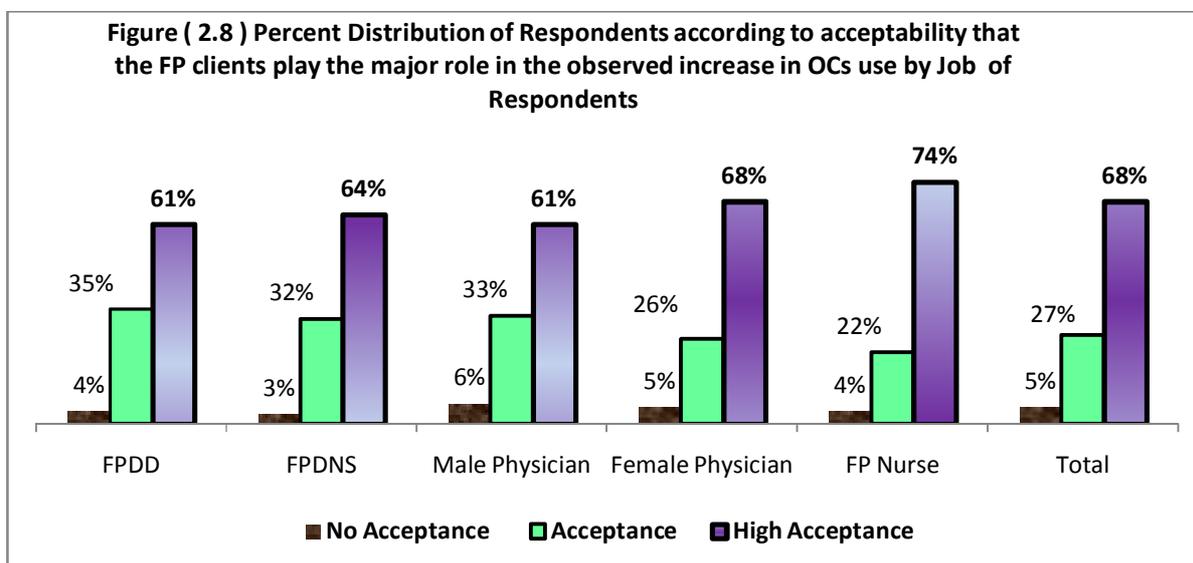


Figure (2.8) Percent Distribution of Respondents according to Acceptability that FP Clients Play a Major Role in the Observed Increase in OC Use by Current Job

Table (2.3) demonstrates factors related to service providers and outreach services contributing for FP method shift towards OCs according to the current job of respondents. As noticed from the table, there was a tendency for FPDD (AS= 43%) and FPDNS (AS= 40%) to

consider that physicians' performance was the major determinant for FP method shift towards OCs. Additionally, FPDD claimed that the nurses' performance was the factor contributing to FP method shift towards OCs (AS= 32%). Male physicians (AS= 33%) and FP nurses (32%) attributed that FP method shift towards OCs was mainly related to performance of the outreach community workers. Yet, there are not statistically significant differences in the AS levels across the respondents of different jobs towards the reasons of shift towards OCs.

Table (2.3) Acceptability score for the factors contributing to FP method shift towards OCs: service providers and outreach workers by Job of respondents

Factors	Acceptability	Current Job of the Respondents						p
		FPDD	FPDNS	Male Physician	Female Physician	FP Nurse	Total	
Physicians	Acceptability Score	43%	40%	32%	30%	37%	35%	0.3
	% of Non-acceptors	42%	48%	58%	61%	53%	54%	
	Total	50	52	55	118	165	440	
Nurses	Acceptability Score	32%	19%	24%	22%	23%	23%	0.06
	% of Non-acceptors	54%	74%	68%	71%	71%	69%	
	Total	48	50	50	116	164	428	
Community Workers	Acceptability Score	17%	27%	33%	28%	32%	29%	0.2
	% of Non-acceptors	76%	65%	60%	64%	59%	63%	
	Total	49	51	53	116	162	431	

Table (2.4) illustrates factors contributing to FP method shift towards OCs (FP operational policies and regulations, problems in management of resources) by Job of respondents. The table displays that there was a tendency for FPDD (AS= 67%) and FPDNS (AS= 60%) to consider that the incentive system was the factor contributing to for FP method shift towards OCs. Additionally, FPDD (AS= 48%) FPDNS (AS= 43%) claimed that the current training system was the factor contributing to FP method shift towards OCs.

Table (2.4) Acceptability score for the factors contributing to FP method shift towards OCs: FP operational policies and regulations, problems in management of resources by Job of respondents

Factors	Acceptability	Current Job of the Respondents						p
		FPDD	FPDNS	Male Physician	Female Physician	FP Nurse	Total	
Incentive System	Acceptability Score	67%	60%	50%	45%	49%	51%	0.1
	% of Non-acceptors	27%	37%	44%	51%	46%	44%	
	Total	51	52	52	117	168	440	
Family Medicine System	Acceptability Score	30%	33%	20%	18%	19%	22%	0.1
	% of Non-acceptors	63%	58%	76%	75%	75%	72%	
	Total	49	48	50	114	159	420	
Family Planning Method Supply	Acceptability Score	13%	16%	27%	25%	29%	24%	0.07
	% of Non-acceptors	84%	81%	67%	71%	69%	72%	
	Total	50	47	51	116	160	424	
Training System	Acceptability Score	48%	43%	41%	41%	38%	41%	0.7
	% of Non-acceptors	42%	48%	53%	49%	54%	50%	
	Total	50	50	51	118	164	433	
Central Supervision	Acceptability Score	4%	0%	12%	8%	6%	6%	0.2
	% of Non-acceptors	94%	100%	84%	90%	92%	92%	
	Total	49	48	51	115	162	425	
Local Supervision	Acceptability Score	5%	0%	10%	6%	4%	5%	0.59
	% of Non-acceptors	94%	100%	88%	93%	94%	94%	
	Total	49	49	49	112	158	417	

Figure (2.9) demonstrates the acceptability score for the different factors contributing to FP method shift to OCs as expressed by FPDD. As noticed from the figure FPDD respondents had endorsed the highest AS for clients as a factor contributing for FP method shift to OCs (AS=85%) followed by the improperly functioning two system i.e. Incentive System (AS = 67%) and Training System (AS= 48%).

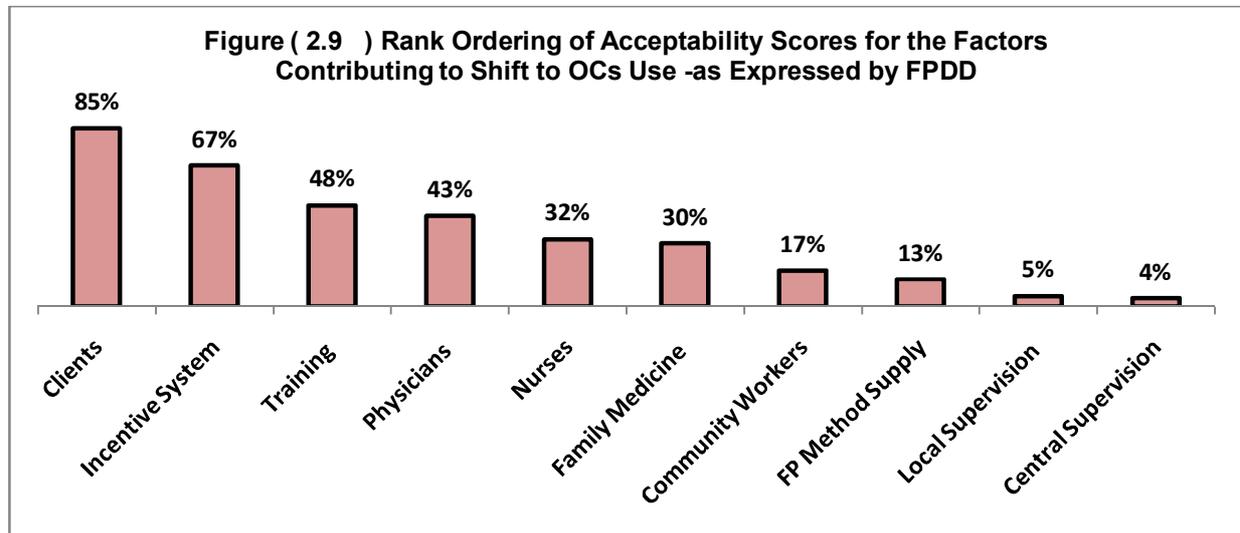


Figure (2.9) Rank Ordering of Acceptability Scores for the Factors Contributing to Shift to OC Use as expressed by FPDD

Figure (2.10) demarcates the acceptability score for the different factors contributing to FP method shift to OCs as expressed by FPDNS. It is clear from the figure FPDNS respondents had focused the highest AS for clients as a factor contributing for FP method shift to OCs to (86%) followed by the improperly functioning two system i.e. Incentive System (AS = 60%) and Training System (AS= 43%).

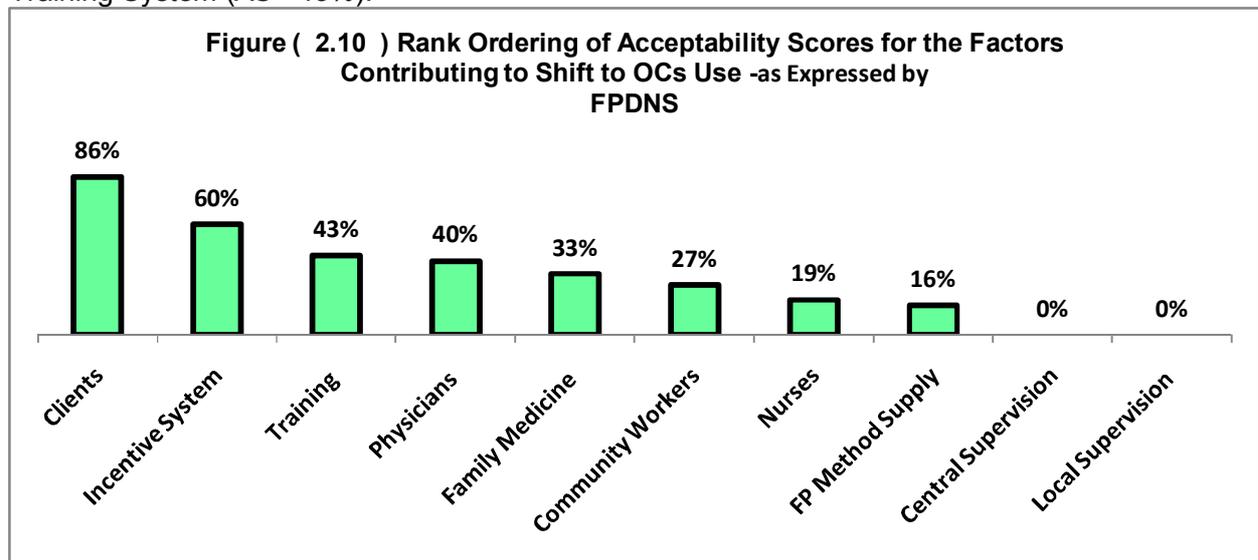


Figure (2.10) Rank Ordering of Acceptability Scores for the Factors Contributing to Shift to OC Use as expressed by FPDNS

Figure (2.11) delineates the acceptability score for the different factors contributing to FP method shift to OCs as expressed by FP Clinics' male physicians. It is obvious that FP Clinics' male physicians considered clients as the major factor contributing for FP method shift to OCs to (AS = 83%) followed by the improperly functioning two system i.e. Incentive System (AS = 50%) and Training System (AS= 41%).

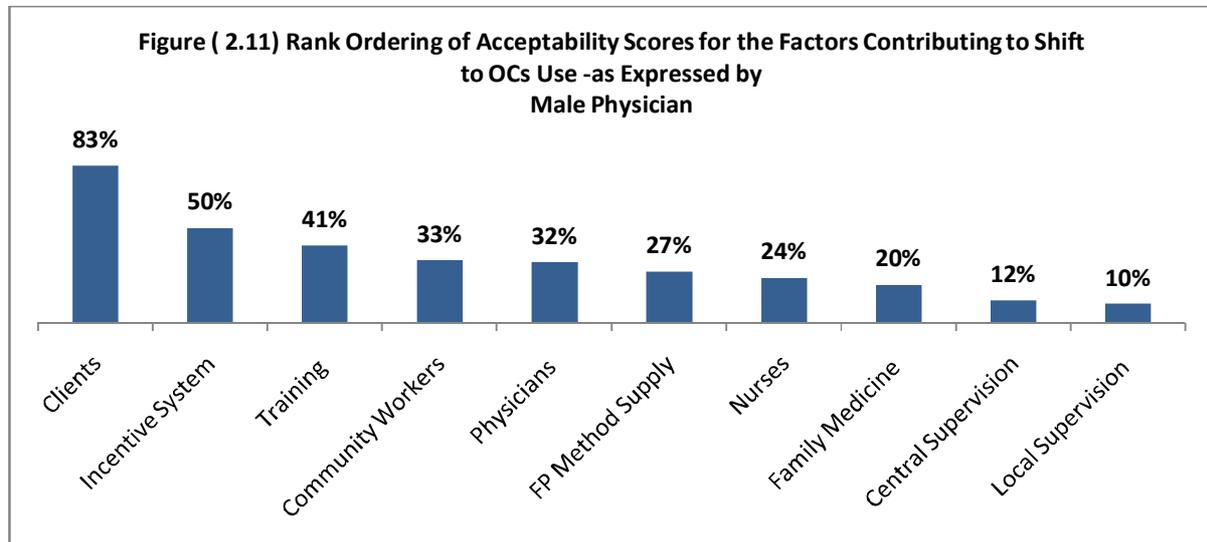


Figure (2.11) Rank Ordering of Acceptability Scores for the Factors Contributing to Shift to OC Use as expressed by FP clinic male physicians

Figure (2.12) highlights the acceptability score for the different factors contributing to FP method shift to OCs as expressed by FP Clinics' female physicians. It could be noticed that FP Clinics' female physicians endorsed clients as the major factor contributing for FP method shift to OCs (86%) followed by the improperly functioning two system i.e. Incentive System (AS = 45%) and Training System (AS= 41%).

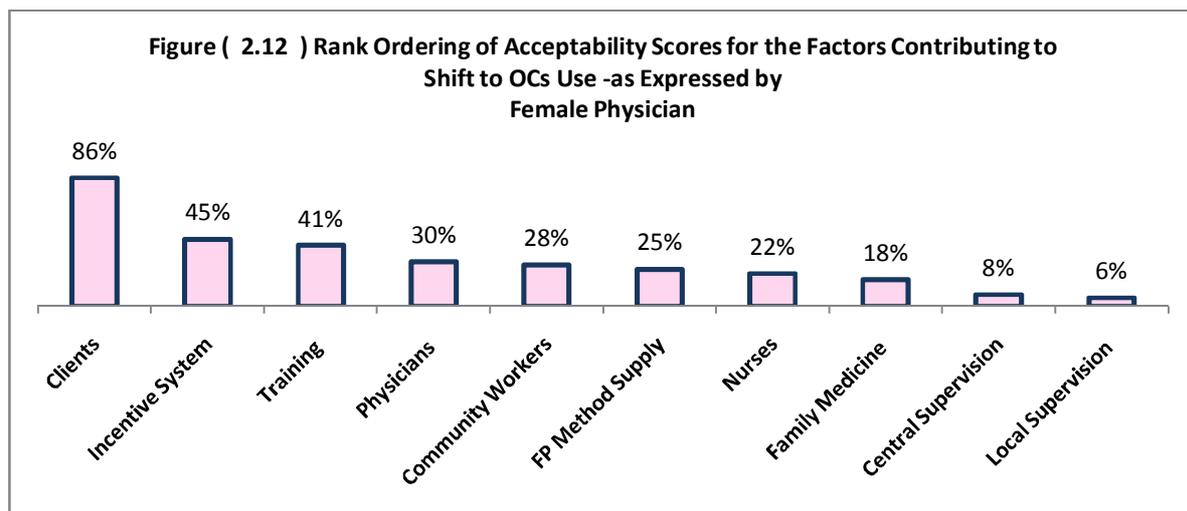


Figure (2.12) Rank Ordering of Acceptability Scores for the Factors Contributing to Shift to OC Use as expressed by FP clinic female physicians

Figure (2.13) demarcates the acceptability score for the different factors contributing to FP method shift to OCs as expressed by FP nurses. It is clear from the figure that FP nurses had expressed the highest AS for clients as a factor contributing for FP method shift to OCs (AS=88%) followed by the improperly functioning two system i.e. Incentive System (AS = 49%) and Training System (AS= 38%).

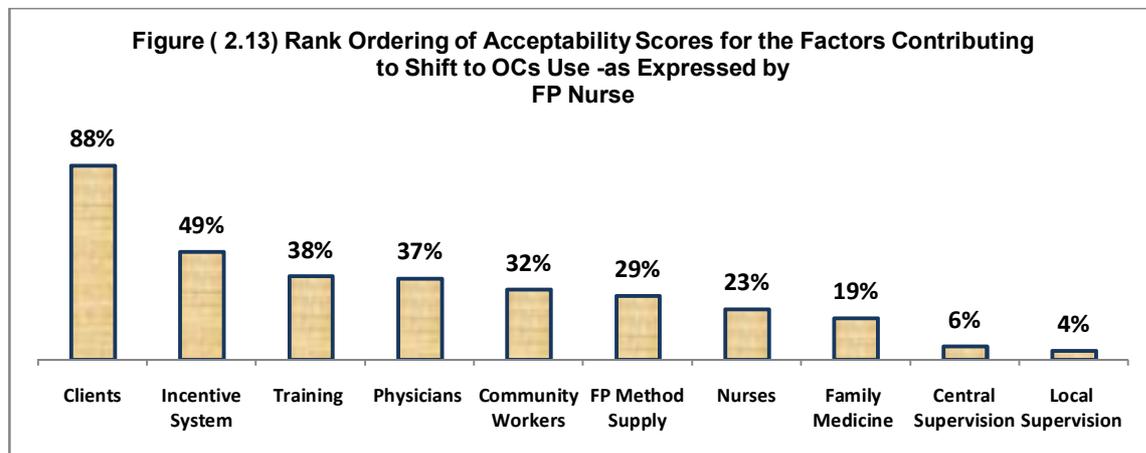


Figure (2.13) Rank Ordering of Acceptability Scores for the Factors Contributing to Shift to OC Use as expressed by FP clinic nurses

The respondents' duration of work in FP could provide another dimensions for the studied issues related to reasons of method shift. As observed from the previous tables and figures that respondents claimed that the clients are the major factor contributing to FP method shift towards OCs. Figure (2.14) illustrates that high proportion (more than 70%) of older generations/or those working in FP more than five years were greatly supporting the view that clients choice for OCs is the major contributing factor for FP method shift towards OCs, than young/ recently involved in FP services (AS= Less than 70%) (Figure 2.14) However, the observed differences across generations regarding the expressed acceptability to the role of clients in FP method mix was not statistically significant ($p=0.14$).

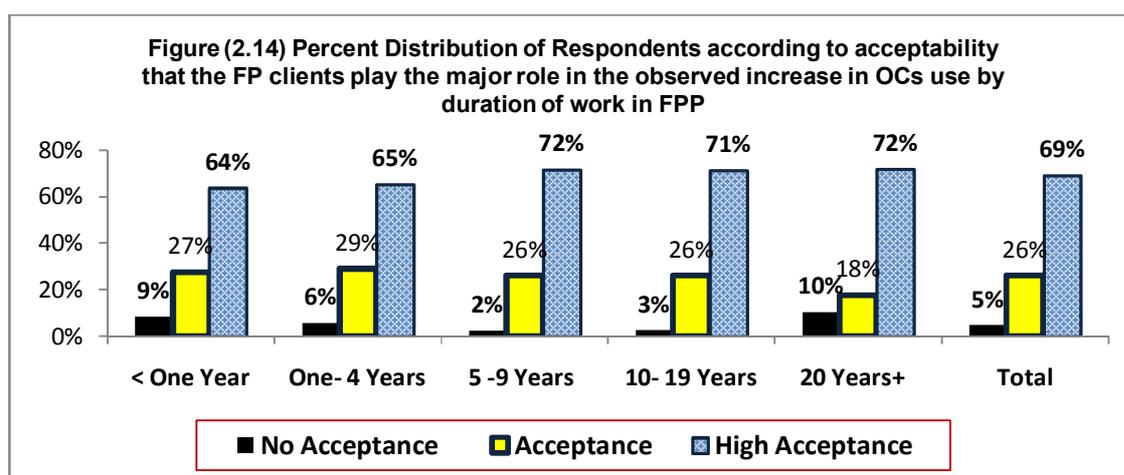


Figure (2.14) Percent Distribution of Respondents according to Acceptability that FP Clients Play a Major Role in the Observed Increase in OCs Use by duration of work in FP services.

Table (2.5) presents respondents' duration of work in FP services and factors related to service providers and outreach services contributing to FP method shift towards OCs. As noticed from the table, there was a tendency for young generations who were recently involved in FP services in reporting high acceptability score to the role of FP physicians in FP method shift with AS= 36% for those worked in FP for less than one year and AS= 40% for those worked in FP for one to less than 5 years. Additionally, younger generations of respondents claimed that the nurses' performance was the factor contributing to FP method shift towards OCs (AS= 27%) as well as the role of community workers (AS= more than 30%). However the observed difference between respondents categorized by the duration of work in FP and the values of AS for different factors contributing to method shift towards OCs were not statistically significant.

Table (2.5) Acceptability score for the factors contributing to FP method shift towards OCs: service providers and outreach workers by respondents' duration of work in FP services

Factors	Acceptability	Duration of Work in FP Program						p
		< One Year	One- 4 Years	5 -9 Years	10- 19 Years	20 Years and more	Total	
Physicians	Acceptability Score	36%	40%	34%	30%	38%	35%	0.7
	% of Non-acceptors	52%	47%	57%	60%	50%	54%	
	Total	44	97	107	139	48	435	
Nurses	Acceptability Score	27%	27%	21%	18%	20%	22%	0.5
	% of Non-acceptors	66%	63%	72%	75%	72%	71%	
	Total	44	93	104	138	47	426	
Community Workers	Acceptability Score	34%	32%	29%	23%	30%	29%	0.6
	% of Non-acceptors	57%	59%	64%	69%	62%	63%	
	Total	42	94	108	137	47	428	

Table (2.6) illustrates factors contributing to FP method shift towards OCs (FP operational policies and regulations, problems in management of resources) by respondents' duration of work in FP. As depicted from the table, there was a tendency for those recently joining the work in FP services to consider the system of management of resources as influencing element in the FP method shift towards OCs use. Those who just spent less than one year in FP services had reported statistically significant high AS for: FP method supply (AS= 38%) and Local Supervision (AS=12%) compared to all those spent one year and more in FP services.

Figure (2.15) summarizes the AS for the different factors contributing to FP method shift towards OCs, estimated for those who worked in FP services for less than five years. It is obvious from the figure that AS for role of the clients was (82%). However, the figure was pointing to the incentive system (AS=59%) training system (AS=47%) and FP method supply (AS= 39%) as factors for method shift.

Figure (2.16) illustrates the perspectives of middle level experienced cohort of respondents (who spend in FP services for 5 to less than ten years) towards the factors contributed to FP method shift towards OCs use. The figure demarcates the presence of consensus between younger cohort (Figure 2.15) regarding ranking the incentive system as the second factor (AS= 55%) after clients role (AS=89%), and ranking the training system as the third factor (AS=39%). However, middle level experienced cohort of respondents highlighted the role of physicians (AS=34%) as an important fourth dimension for FP method shift.

Table (2.6) Acceptability score for the factors contributing to FP method shift towards OCs:FP operational policies and regulations, problems in management of resourcesby respondents' duration of work in FP services

Factors	Acceptability	Duration of Work in FP Program					Total	p
		< One Year	One- 4 Years	5 -9 Years	10- 19 Years	20 Years and more		
Incentive System	Acceptability Score	59%	50%	55%	50%	46%	52%	0.84
	% of Non-acceptors	36%	47%	40%	45%	50%	44%	
	Total	44	101	105	139	4600%	435	
Family Medicine System	Acceptability Score	32%	23%	20%	19%	27%	22%	0.48
	% of Non-acceptors	61%	70%	73%	76%	66%	71%	
	Total	41	87	105	137	47	417	
Family Planning Method Supply	Acceptability Score	38%	32%	23%	14%	19%	23%	0.00
	% of Non-acceptors	60%	60%	74%	84%	78%	73%	
	Total	42	93	105	134	45	419	
Training System	Acceptability Score	47%	46%	39%	36%	40%	40%	0.35
	% of Non-acceptors	43%	43%	52%	57%	54%	51%	
	Total	42	95	104	139	50	430	
Central Supervision	Acceptability Score	13%	9%	5%	3%	7%	6%	0.09
	% of Non-acceptors	83%	88%	93%	96%	89%	92%	
	Total	41	91	104	139	47	422	
Local Supervision	Acceptability Score	12%	6%	4%	2%	4%	4%	0.04
	% of Non-acceptors	85%	93%	95%	98%	93%	94%	
	Total	40	89	103	138	45	415	

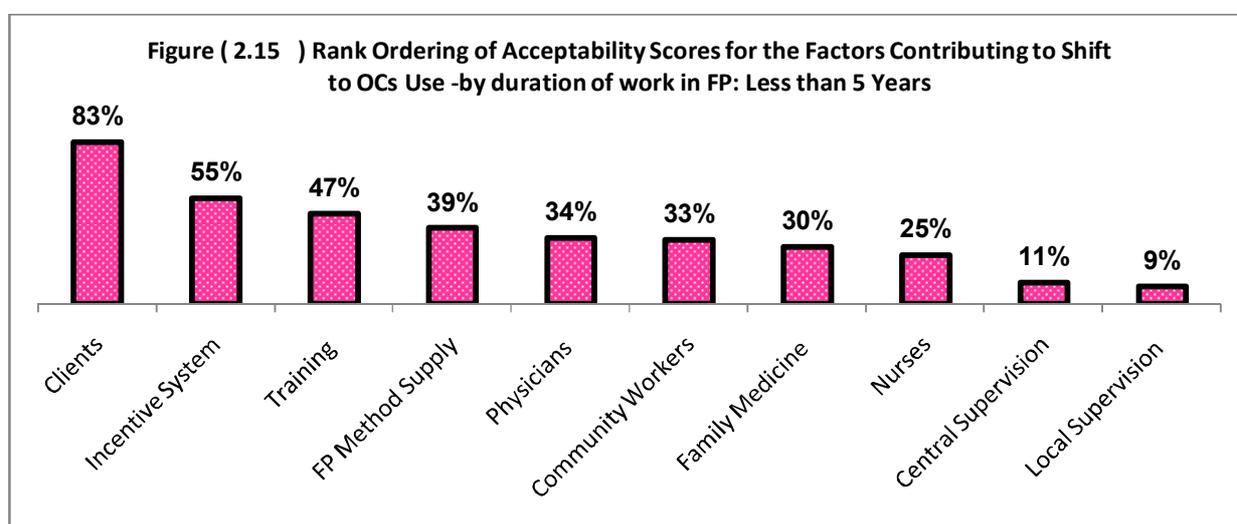


Figure (2.15) Rank Ordering of Acceptability Scores for the Factors Contributing to Shift to OC Use -by duration of work in FP:Less than 5 Years

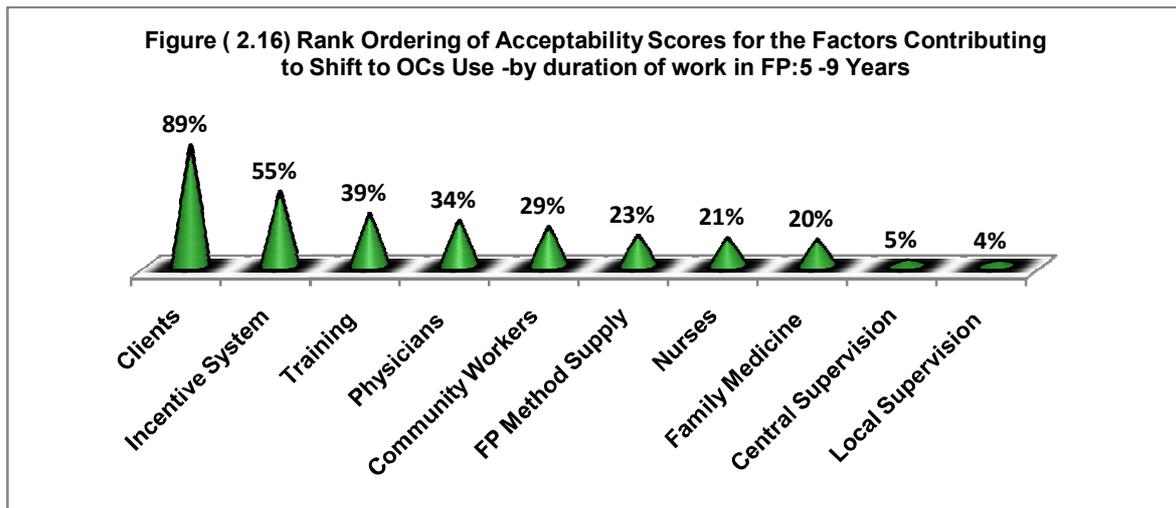


Figure (2.16) Rank Ordering of Acceptability Scores for the Factors Contributing to Shift to OC Use -by duration of work in FP:5 -9 Years

Information pertaining to the perspectives of highly experienced cohort of respondents, who spend in FP services for 10 years and more, towards the factors contributed to FP method shift towards OCs is shown in Figure (2.17). The figure demarcates the presence of consensus between younger cohort (Figure 2.15) regarding ranking the incentive system as the second factor (AS= 48%) after clients role (AS=86%), and ranking the training system as the third factor (AS=38%) and FP method supply as the fourth factor (AS=34%).

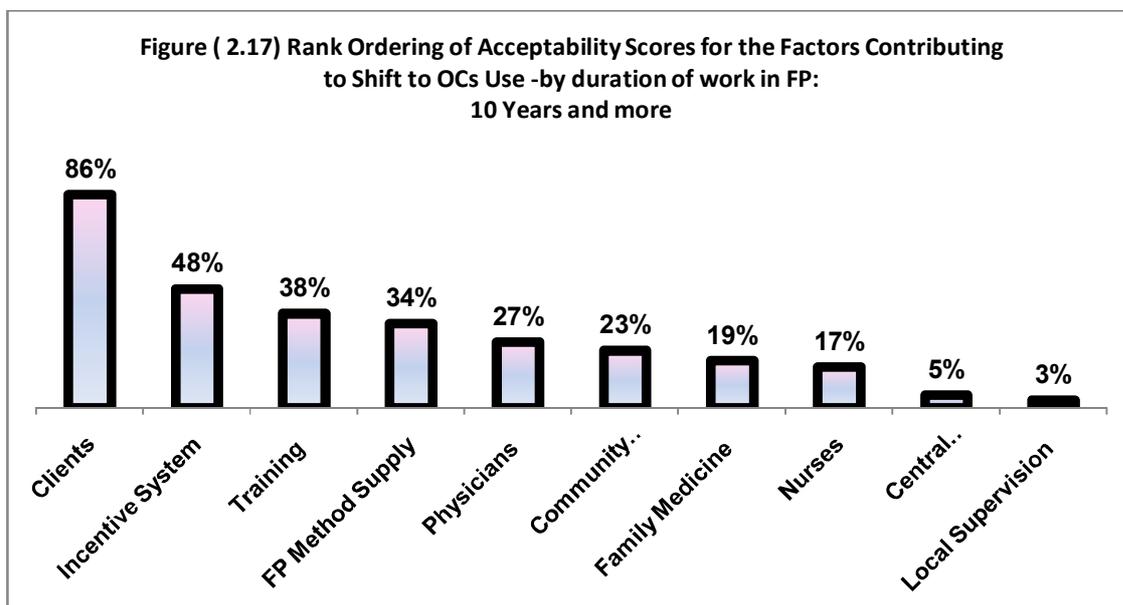


Figure (2.17) Rank Ordering of Acceptability Scores for the Factors Contributing to Shift to OC Use -by duration of work in FP: 10 Years and more

[3] Acceptability of OCs by users as expressed by Respondents:

Justification expressed by respondents for mentioning that clients' role was pivotal in FP method shift towards OCs use had been investigated and demonstrated in figure (3.1). The figure demarcates that respondents considered that clients prefer OCs because of they have control over choosing and using the pills at any time and stop using at any time without consultation of any medical or non-medical personnel (AS= 79%). Reasonable price of OCs, as well, attract clients to use OCs (AS= 75%). Availability of the OCs at any time in MOHP clinics motivate women to use this method (AS =68%), as their availability support their control over using this method. Additionally, using this method satisfy women's psychological character related to dislike of gynecological examination and medical procedures (AS= 66%).

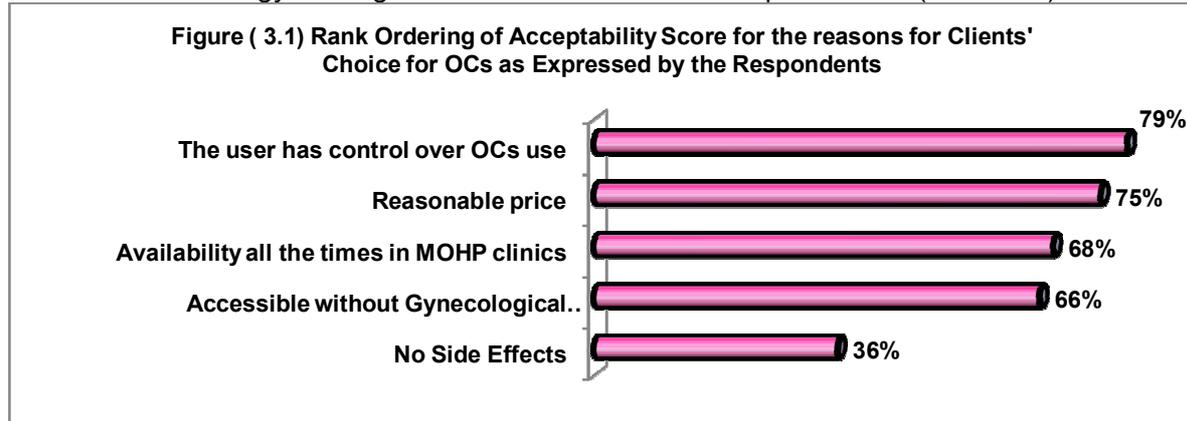


Figure (3.1) Rank Ordering of Acceptability Score for the reasons for Clients' Choice for OCs as Expressed by the Respondents

The views of respondents showed statistically significant variations across the governorates regarding justification of the reasons for women choosing OCs. Respondents from Beni-Suef supported the views of availability of OCs in MOHP clinics at any time (AS =90%), reasonable price (AS =85%) and no side effects (AS= 57%). Respondents from Sharkia supported the view that the OCs users have control over using the method (AS=87%). However, there was a consensus across respondents across the governorate that women prefer OCs due to accessibility to the method without gynecological examination or intervention.

Table (3.1) Acceptability score for the reasons for Clients' Choice for OCs as Expressed by the Respondents by Governorates

Advantages Of OCs	Acceptability	Governorates					Total	P
		Cairo	Fyoum	Menofia	Beni-Suef	Sharkia		
Availability all the times in MOHP clinics	Acceptability Score	55%	74%	69%	90%	58%	68%	0.00
	% of Non-acceptors	39%	13%	22%	5%	35%	24%	
	Total	96	93	125	96	150	560	
No need for Gynecological Examination	Acceptability Score	68%	65%	63%	66%	70%	66%	0.21
	% of Non-acceptors	19%	19%	27%	23%	17%	21%	
	Total	97	94	131	99	151	572	
No Side Effects	Acceptability Score	38%	18%	36%	57%	33%	36%	0.00
	% of Non-acceptors	50%	74%	54%	36%	57%	54%	
	Total	92	85	112	97	148	534	
Reasonable price	Acceptability Score	74%	71%	72%	85%	74%	75%	0.00
	% of Non-acceptors	13%	12%	18%	7%	18%	14%	
	Total	97	92	120	97	148	554	
The user has control over OCs use	Acceptability Score	77%	77%	76%	73%	87%	79%	0.00
	% of Non-acceptors	9%	5%	16%	16%	3%	10%	
	Total	97	88	136	92	149	562	

Figures (3.2, 3.3, 3.4, 3.5 and 3.6) illustrate the justifications for women to be motivated towards choosing OCs, as expressed by respondents. Figure (3.2) reflects the views of respondents from Cairo Governorate. It is obvious that respondents supported the view that women's autonomy in using OCs was the most acceptable reason (AS = 77%) followed by the reasonable price of OCs (AS= 74%).

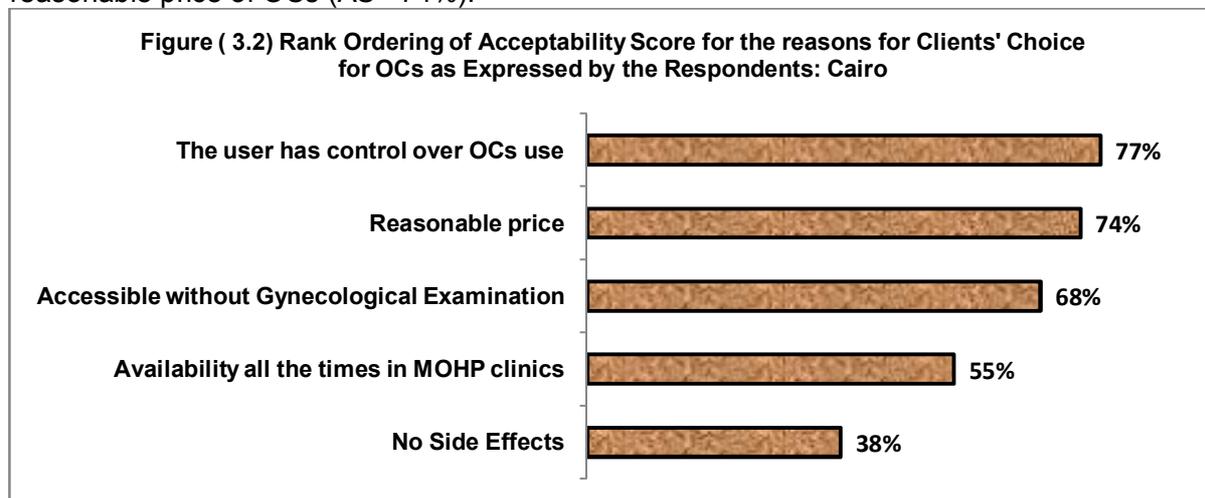


Figure (3.2) Acceptability score for the reasons for Clients' Choice for OCs as Expressed by the Respondents by Governorates: Cairo

Figure (3.3) illustrates the views of respondents from Fayoum Governorate. It is obvious that respondents supported the view that women's autonomy in using OCs was the most acceptable reason (AS = 77%) followed by availability of the method in MOHP clinics all the time (AS= 74%).

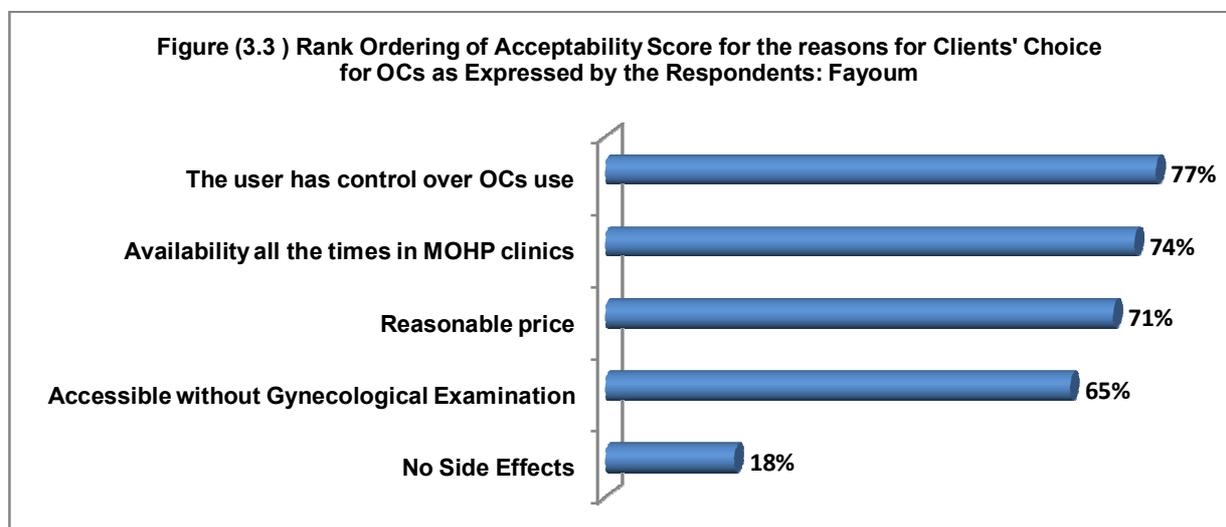


Figure (3.3) Acceptability score for the reasons for Clients' Choice for OCs as Expressed by the Respondents by Governorate: Fayoum

Figure (3.4) reflects the views of respondents from Menofia Governorate. It is obvious that respondents supported the view that women's autonomy in using OCs was the most acceptable reason (AS = 76%) followed by the reasonable price of OCs (AS= 72%).

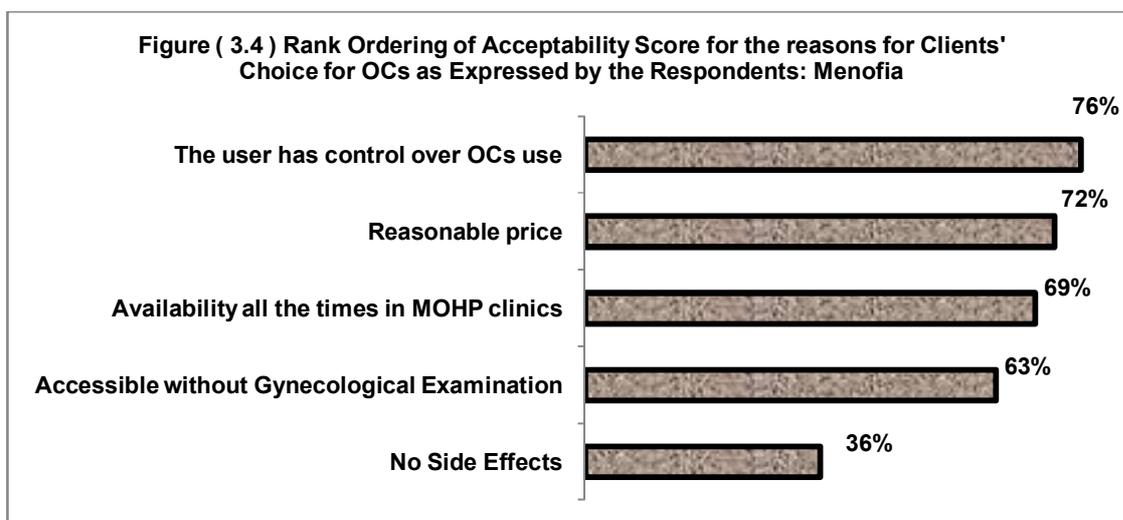


Figure (3.4) Acceptability score for the reasons for Clients' Choice for OCs as Expressed by the Respondents by Governorate: Menofia

Figure (3.5) demonstrates the views of respondents from Beni-Suef Governorate. It is obvious that respondents supported the view that availability of OCs in MOHP clinics to be accessible to clients at any time is the major driving dynamic to make women more inclined to use OCs (AS= 90%).

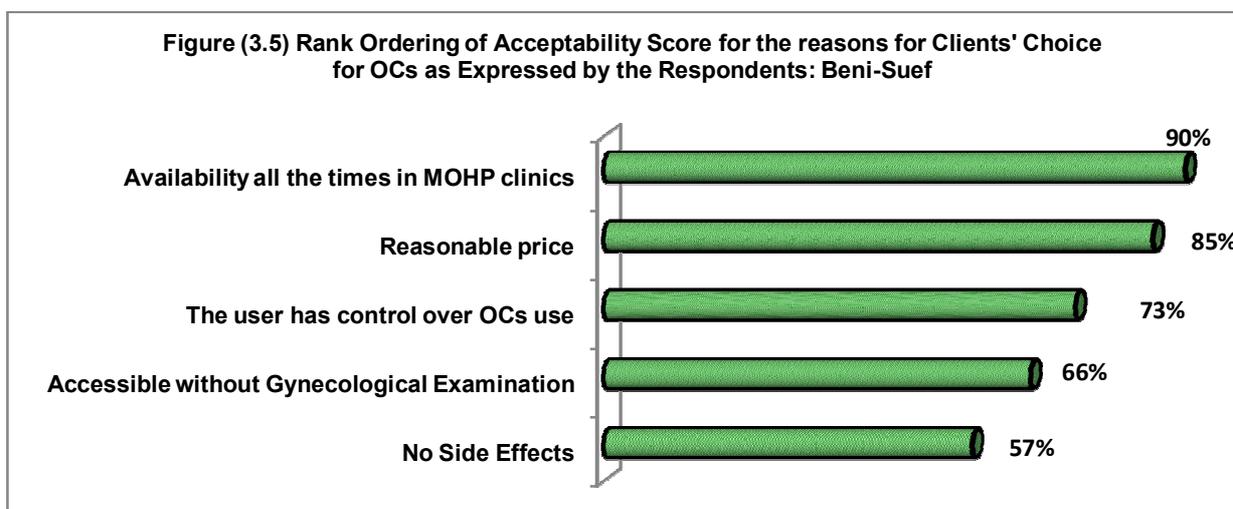


Figure (3.5) Acceptability score for the reasons for Clients' Choice for OCs as Expressed by the Respondents by Governorate: Beni-Suef

Figure (3.6) shows the views of respondents from Sharkia Governorate. It is obvious that respondents supported the interpretation that women has the autonomy to control the use of OCs compared to other FP methods (AS =87%). Reasonable price was the second reason for women more to be inclined to use OCs (AS= 74%).

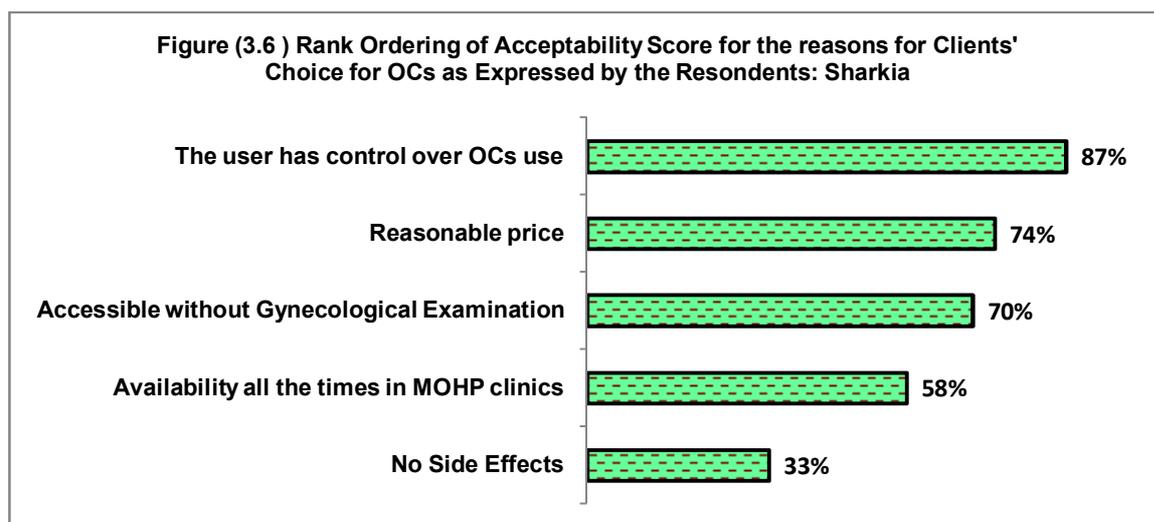


Figure (3.6) Acceptability score for the reasons for Clients' Choice for OCs as Expressed by the Respondents by Governorate: Sharkia

Table (3.2) adds an important issue related to contraceptive dynamics. The table illustrates the acceptability score for the reasons for clients' choice for OCs as expressed by the respondents according to their current job. It is obvious that there was a consensus (no statistically significant difference) among all respondents assigned to different positions in the FP services hierarchy regarding three determinants: availability of OCs in MOHP clinics all the time, no need for gynecological interventions and the user has control over OCs use. However, significantly high proportion (64%) of female physicians demarcated non-acceptance that women use OCs because of the minimal side effects ($p=0.01$). A significant proportion of nurses (79%) working in FP pointed out that the driving dynamic for women to use OCs is the low price of the pills ($p=0.03$).

Table (3.2) Acceptability score for the reasons for Clients' Choice for OCs as Expressed by the Respondents according to their current job

Advantages Of OCs	Acceptability	Current Job of the Respondents						p
		FPDD	FPDNS	Male Physician	Female Physician	FP Nurse	Total	
Availability all the times in MOHP clinics	Acceptability Score	59%	67%	77%	66%	70%	68%	0.13
	% of Non-acceptors	31%	26%	16%	26%	22%	24%	
	Total	55	57	70	139	203	524	
Accessible without Gyn. Examination	Acceptability Score I	72%	75%	67%	64%	67%	68%	0.14
	% of Non-acceptors	14%	11%	17%	24%	21%	19%	
	Total	57	62	69	147	204	539	
No Side Effects	Acceptability Score	39%	39%	35%	28%	42%	36%	0.01
	% of Non-acceptors	49%	49%	56%	64%	49%	54%	
	Total	53	59	68	136	187	503	
Reasonable price	Acceptability Score	74%	75%	77%	69%	79%	75%	0.03
	% of Non-acceptors	15%	12%	13%	18%	12%	14%	
	Total	55	59	69	138	198	519	
The user has control over OCs use	Acceptability Score	82%	80%	74%	80%	79%	79%	0.13
	% of Non-acceptors	5%	5%	13%	9%	10%	9%	
	Total	57	59	69	141	202	528	

Table (3.3) marks out that there was a consensus among all respondents categorized according to the duration of work in FP services, for all the five parameters related to the driving forces for women to use OCs (p for all parameters was more than 0.05). However, it is obvious that young cohorts (working in FP for less than 5 years) and experienced cohorts (working in FP 10 years and more) had reported highest AS (about 80%) for the parameter related to women prefer using OCs because of self-rule/autonomy in choosing and using the method.

Table (3.3) Acceptability score for the reasons for Clients' Choice for OCs as Expressed by the Respondents according to their duration of work in FP services

Advantages Of OCs	Acceptability	Duration of Work in FP Program					Total	p
		< One Year	One- 4 Years	5 -9 Years	10- 19 Years	20 Years & more		
Availability all the times in MOHP clinics	Acceptability Level	71%	74%	68%	61%	72%	68%	0.21
	% of Non-acceptors	21%	17%	23%	32%	21%	24%	
	Total	57	116	124	153	58	508	
Accessible without Gynecological Examination	Acceptability Level	68%	67%	69%	66%	63%	67%	0.68
	% of Non-acceptors	18%	19%	21%	25%	20%	20%	
	Total	62	125	125	151	57	520	
No Side Effects	Acceptability Level	39%	39%	35%	28%	42%	36%	0.32
	% of Non-acceptors	49%	49%	56%	64%	49%	54%	
	Total	53	59	68	136	187	503	
Reasonable price	Acceptability Level	74%	75%	77%	69%	79%	75%	0.21
	% of Non-acceptors	15%	12%	13%	18%	12%	14%	
	Total	55	59	69	138	198	519	
The user has control over OCs use	Acceptability Level	82%	80%	74%	80%	79%	79%	0.68
	% of Non-acceptors	5%	13%	9%	10%	9%	9%	
	Total	57	59	69	141	202	528	

[4] Leakage OCs from MOHP FP-Clinics to other outlets!

To investigate the hypothesis that, there is no true increase in OCs users, and the service statistics reflects dispensed OCs rather than true users, the respondents were asked about any observed leakage of OCs from FP clinics to other outlets. The responses to this issue were analyzed and presented in three tables. Table (4.1) illustrates the AS of respondents, categorized by governorates, about leakage of OCs outside FP clinics. Eight percent of the respondents (AS=7%) affirmed the leakage of OCs from FP clinics. However, as depicted from the table there were significant variations between respondents from different governorates regarding this issue. Beni-Suef respondents reported the highest AS (18%) for the observed leakage of OCs to pharmacies (AS=18%) and other places (AS=20%).

Table (4.1) Acceptability score for the Respondents views towards leakage of OCs from MOHP-FP clinics to other places, by governorates

Leakage of OCs to:	Acceptability	Governorates					Total	p
		Cairo	Fyou m	Menof ia	Beni-Suef	Shark ia		
Pharmacies	Acceptability Level	4%	8%	8%	18%	2%	7%	0.02
	% of Non-acceptors	95%	91%	91%	80%	97%	92%	
	Total	81	64	99	59	146	449	
Other locations	Acceptability Level	6%	6%	7%	20%	3%	7%	0.002
	% of Non-acceptors	93%	92%	92%	77%	97%	92%	
	Total	81	62	98	64	145	450	

Table (4.2) shows the AS of respondents, categorized by current job, about leakage of OCs outside FP clinics. As depicted from the table there were insignificant variations between respondents from of different jobs regarding this issue. However, FPDD and female physicians had reported the highest AS for the observed leakage of OCs to pharmacies and other places compared to respondents assigned to other jobs.

Table (4.2) Acceptability score for the Respondents views towards leakage of OCs from MOHP-FP clinics to other places by current job of respondents in FP services

Leakage of OCs to:	Acceptability	Current Job of the Respondents						p
		FPDD	FPDNS	Male Physician	Female Physician	FP Nurse	Total	
Pharmacies	Acceptability Level	9%	3%	7%	8%	7%	7%	0.17
	% of Non-acceptors	89%	96%	93%	91%	92%	92%	
	Total	47	49	55	117	153	421	
Other locations	Acceptability Level	11%	1%	6%	10%	6%	7%	0.18
	% of Non-acceptors	87%	98%	93%	88%	93%	91%	
	Total	46	49	55	117	155	422	

Table (4.3) illustrates the AS of respondents, categorized by duration of work in FP services, about their views about leakage of OCs outside FP clinics. As portrayed in the table there were insignificant variations between respondents from different cohorts regarding this issue. However, younger cohort who just working in FP services for less than one year had affirmed the observation of leakage of OCs outside the FP clinics to pharmacies (AS=9%) and/or other places (AS=14%).

Table (4.3) Acceptability score for the Respondents views towards leakage of OCs from MOHP-FP clinics to other places by duration of work in FP services

Leakage of OCs to:	Acceptability	Duration of Work in FP Program					Total	p
		< One Year	One-4 Years	5-9 Years	10-19 Years	20 Years and more		
Pharmacies	Acceptability Level	9%	7%	7%	5%	6%	6%	0.27
	% of Non-acceptors	88%	91%	92%	95%	94%	93%	
	Total	43	93	102	125	47	410	
Other locations	Acceptability Level	14%	7%	6%	5%	6%	7%	0.12
	% of Non-acceptors	82%	91%	93%	94%	94%	92%	
	Total	44	95	102	125	47	413	

[5] Causes of shift from IUD to OCs

The study respondents had been asked about their views for the observed service statistics that delineates that FP clients' shift from IUD use to OCs use. Figure (5.1) highlights important situation regarding the management component of FP services regarding incentive system and training. It could be realize that those who work in FP services consider IUD insertion requires extra efforts from the physicians so as to get incentives per inserted IUDs (AS =64%). Such efforts extend beyond insertion to follow up services of IUD users (AS=51%). Therefore, the work regulations do not motivate physicians to provide IUD insertion services with subsequent directing of women to use methods that do not need any effort from the physician e.g. OCs.

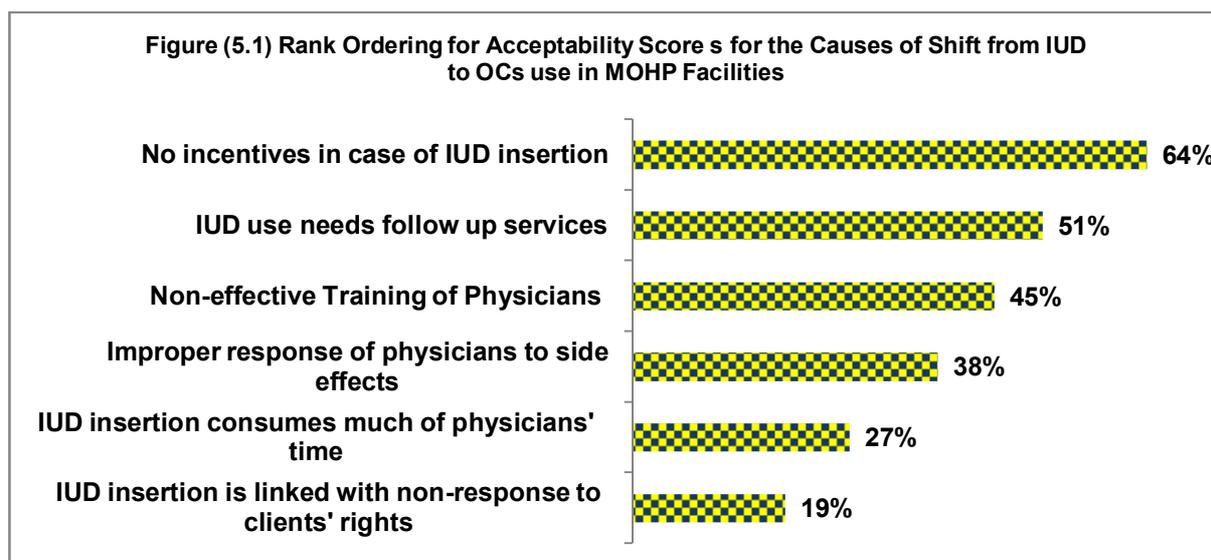


Figure (5.1) Acceptability score for the Respondents views towards causes of FP method shift from IUD to OCs

Table (5.1) demonstrates the acceptability score for the respondents views towards causes of FP method shift from IUD to OCs by Governorates. It is obvious that there were statistically significant differences across governorates regarding the investigated six items that restrict providing the service of IUD insertion. Specifically, respondents from Beni-Suef expressed the highest AS for the six items.

Table (5.1) Acceptability score for the Respondents views towards causes of FP method shift from IUD to OCs by Governorates

Causes of shift from IUD to OCs	Acceptability	Governorates					Total	P
		Cairo	Fyoum	Menofia	Beni-Suef	Sharkia		
Non-effective Training of Physicians	Acceptability Level	27%	42%	45%	67%	43%	45%	0.00
	% of Non-acceptors	66%	43%	48%	24%	47%	46%	
	Total	93	88	141	96	150	568	
Improper response of physicians to side effects	Acceptability Level	22%	37%	38%	58%	37%	38%	0.00
	% of Non-acceptors	70%	48%	52%	31%	52%	51%	
	Total	94	86	120	93	149	542	
No incentives in case of IUD insertion	Acceptability Level	60%	68%	49%	74%	71%	64%	0.00
	% of Non-acceptors	33%	19%	46%	18%	20%	28%	
	Total	96	89	137	91	147	560	
IUD use needs follow up services	Acceptability Level	50%	59%	47%	62%	44%	51%	0.00
	% of Non-acceptors	36%	18%	41%	23%	40%	33%	
	Total	96	92	116	92	149	545	
IUD insertion consumes much of physicians' time	Acceptability Level	22%	45%	18%	39%	20%	27%	0.00
	% of Non-acceptors	72%	40%	77%	55%	73%	65%	
	Total	89	86	114	89	145	523	
IUD insertion is linked with non-response to clients' rights	Acceptability Level	11%	17%	12%	47%	15%	19%	0.00
	% of Non-acceptors	84%	79%	85%	47%	82%	76%	
	Total	89	86	114	89	145	523	

Table (5.2) displays the acceptability score for the Respondents views towards causes of FP method shift from IUD to OCs by current Job of Respondents. It is clear from the table the statistically significant variations between respondents assigned to different jobs regarding three issues related to FP method shift from IUD to OCs. For example significant proportion of male physicians (56%) expressed non-acceptance that physicians are improperly responding to side effects of IUD (56%) and they considered that the follow up services to IUD users could restrict providing IUD insertion services (73%). FPDD and FPDNS considered that the issue of incentives is the driving force for method shift from IUD to OCs.

Table (5.2) Acceptability score for the Respondents views towards causes of FP method shift from IUD to OCs by current Job of Respondents

Causes of shift from IUD to OCs	Acceptability	Current Job of the Respondents						p
		FPDD	FPDNS	Male Physician	Female Physician	FP Nurse	Total	
Non-effective Training of Physicians	Acceptability Level	49%	49%	43%	45%	47%	47%	0.23
	% of Non-acceptors	38%	38%	48%	45%	44%	43%	
	Total	56	58	69	145	205	533	
Improper response of physicians to side effects	Acceptability Level	41%	41%	37%	40%	39%	40%	0.007
	% of Non-acceptors	42%	47%	56%	45%	51%	49%	
	Total	55	57	68	137	191	508	
No incentives in case of IUD insertion	Acceptability Level	76%	77%	66%	62%	61%	65%	0.017
	% of Non-acceptors	14%	13%	28%	31%	31%	27%	
	Total	56	62	68	142	199	527	
IUD use needs follow up services	Acceptability Level	48%	39%	53%	51%	56%	51%	0.002
	% of Non-acceptors	35%	46%	27%	33%	31%	33%	
	Total	54	57	70	135	195	511	
IUD insertion consumes much of physicians' time	Acceptability Level	30%	33%	24%	26%	27%	28%	0.39
	% of Non-acceptors	60%	57%	70%	65%	66%	65%	
	Total	53	56	66	130	188	493	
IUD insertion is linked with non-response to clients' rights	Acceptability Level	11%	18%	21%	20%	23%	20%	0.13
	% of Non-acceptors	85%	75%	75%	76%	72%	75%	
	Total	53	57	64	134	185	493	

Table (5.3) presents the acceptability score for the respondents' views towards causes of FP method shift from IUD to OCs by duration of work in FP services. It is clear from the table that there was a consensus among different cohorts of respondents regarding the elements that lead to shift from IUD use to OCs use. However, there was statistically significant different among cohorts of respondents regarding the issue of "improper response of physicians to side effects of IUD" (p= 0.004). While young cohort worked for 1-<5 years in FP expressed acceptance of "improper response of physicians to side effects of IUD" (AS=49%), older cohorts worked for 10-<20 years in FP had precluded this statement (AS= 29%).

Table (5.3) Acceptability score for the Respondents views towards causes of FP method shift from IUD to OCs by duration of work in FP Services

Causes of shift from IUD to OCs	Acceptability	Duration of Work in FP Program					Total	p
		< One Year	One- 4 Years	5 -9 Years	10- 19 Years	20 Years and more		
Non-effective Training of Physicians	Acceptability Level	50%	50%	48%	39%	48%	46%	0.52
	% of Non-acceptors	39%	40%	41%	52%	43%	44%	
	Total	61	121	124	149	56	511	
Improper response of physicians to side effects	Acceptability Level	42%	49%	44%	29%	33%	39%	0.004
	% of Non-acceptors	47%	35%	45%	61%	55%	49%	
	Total	57	110	121	147	55	490	
No incentives in case of IUD insertion	Acceptability Level	64%	68%	66%	64%	56%	65%	0.61
	% of Non-acceptors	30%	23%	25%	28%	35%	27%	
	Total	57	119	128	149	54	507	
IUD use needs follow up services	Acceptability Level	57%	53%	51%	50%	51%	52%	0.59
	% of Non-acceptors	23%	30%	34%	35%	33%	32%	
	Total	56	111	123	147	57	494	
IUD insertion consumes much of physicians' time	Acceptability Level	28%	27%	28%	28%	28%	28%	0.85
	% of Non-acceptors	65%	63%	65%	65%	63%	64%	
	Total	52	103	121	144	52	472	
IUD insertion is linked with non-response to clients' rights	Acceptability Level	20%	21%	22%	15%	28%	20%	0.47
	% of Non-acceptors	76%	74%	74%	81%	65%	75%	
	Total	54	107	119	145	52	477	

[6] Capitalizing on physicians to increase IUD use

The current study had tested the respondents' views vis-à-vis the interventions to promote the role of physicians in IUD insertion services. Table (6.1) presents the AS to the suggested arrangements to motivate physicians for providing IUD insertion services. It is obvious that there was no consensus across the governorates ($p=0.00$) regarding the suggested arrangement. A significant proportion of respondents from Menofia (93%) expressed acceptance of arrangement of submission of training certificate after insertion of 5 IUDs. However, 46% of respondents from Cairo had rejected this arrangement. Hundred percent of respondents from Sharkia had expressed acceptance of incentives in case of IUD insertion, while, 11% of respondents from Beni-Suef had banned this arrangement.

Table (6.1) Acceptability score for the Respondents views towards intervention to promote the role of physicians in IUD insertion services by Governorates

How to promote the role of doctors in IUD use	Acceptability	Governorates					Total	P
		Cairo	Fyoun	Menofia	Beni-Suef	Sharkia		
Training Certificate-after insertion of 5 IUDs	Acceptability Level	44%	71%	85%	80%	82%	74%	0.00
	% of Non-acceptors	46%	13%	7%	14%	10%	16%	
	Total	94	85	137	87	149	552	
Incentives in case of IUD insertion according to quality standards	Acceptability Level	86%	85%	82%	88%	95%	87%	0.00
	% of Non-acceptors	6%	3%	11%	4%	0%	5%	
	Total	99	88	137	92	149	565	

Table (6.2) presents the AS to the suggested arrangements to motivate physicians to provide IUD insertion services by current job of the respondents. It is clear that there was no consensus across the respondents assigned to different jobs in the hierarchy of FP services ($p < 0.05$)

regarding the suggested arrangement. A significant proportion of male physicians (90%) expressed acceptance of arrangement of training certificate after insertion of 5 IUDs versus (72%) of FPDD. Ninety nine percent of male physicians had expressed acceptance of incentives in case of IUD insertion, versus 94% of FP nurses.

Table (6.2) Acceptability score for the Respondents views towards intervention to promote the role of physicians in IUD insertion services by current job of respondents

How to promote the role of doctors in IUD use	Acceptability	Current Job of the Respondents						p
		FPDD	FPDNS	Male Physician	Female Physician	FP Nurse	Total	
Training Certificate-after insertion of 5 IUDs	Acceptability Level	64%	66%	83%	79%	78%	76%	0.02
	% of Non-acceptors	27%	26%	10%	12%	13%	15%	
	Total	56	58	63	139	200	516	
Incentives in case of IUD insertion according to quality standards	Acceptability Level	93%	92%	96%	85%	84%	88%	0.00
	% of Non-acceptors	4%	5%	1%	6%	6%	5%	
	Total	57	63	68	143	198	529	

Table (6.3) presents the AS to the suggested arrangements to motivate physicians to provide IUD insertion services by duration of work in FP services. It is obvious that despite the tendency for young cohort of respondents (working in FP for less than one year) to record high AS for the suggested two arrangements to motivate physicians to provide IUD insertion services (i.e. Training Certificate-after insertion of 5 IUDs and Incentives in case of IUD insertion according to quality standards), there was a consensus among all cohorts of respondents to accept the suggested two arrangements to motivate physicians to provide IUD insertion services ($p > 0.05$).

Table (6.3) Acceptability score for the Respondents views towards intervention to promote the role of physicians in IUD insertion services by duration of work in FP services

How to promote the role of doctors in IUD use	Acceptability	Duration of Work in FP Program						p
		< One Year	One- 4 Years	5 -9 Years	10- 19 Years	20 Years and more	Total	
Training Certificate-after insertion of 5 IUDs	Acceptability Level	85%	72%	74%	70%	73%	73%	0.2
	% of Non-acceptors	6%	19%	18%	18%	20%	17%	
	Total	54	122	123	146	54	499	
Incentives in case of IUD insertion according to quality standards	Acceptability Level	92%	88%	86%	90%	92%	89%	0.6
	% of Non-acceptors	2%	4%	6%	3%	4%	4%	
	Total	59	120	126	153	55	513	

[7] Acceptability of having a role for trained nurse in IUD insertion.

The current study had tested the hypothesis that “trained nurse **could be permitted to conduct IUD insertion in FP clinics**”. The views of the study respondent to this hypothesis was investigated and analyzed and presented in figure (7.1). It is obvious that non-accepting the suggested arrangement dominated the views of the respondents (65%).

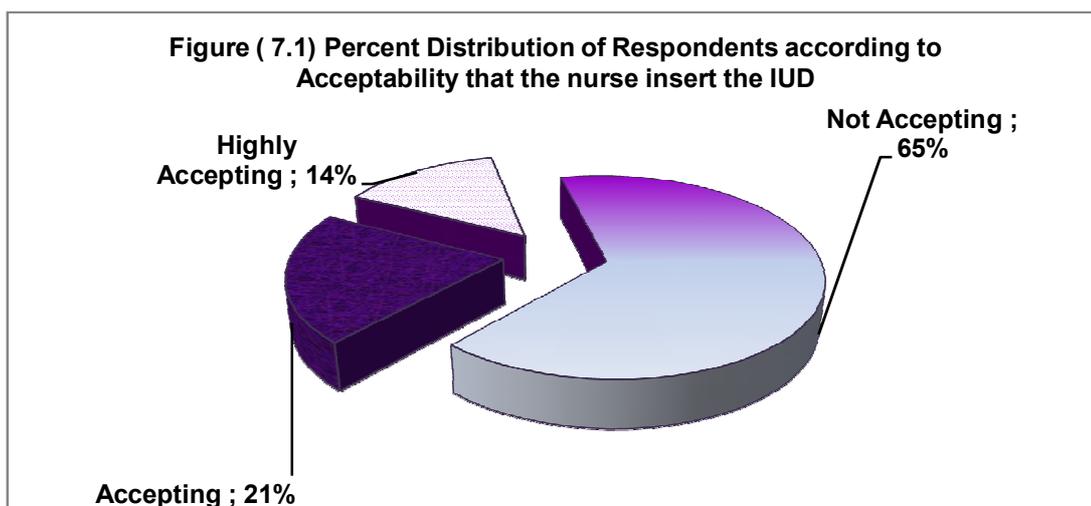


Figure (7.1) Percent Distribution of Respondents according to Acceptability that the nurse could provide IUD insertion services

Figure (7.2) displays the percent distribution of respondents according to acceptability that the trained nurse is eligible to insert the IUD by governorate. The figure delineates significant variations across governorates ($P=0.00$) regarding acceptability that the trained nurse could be eligible for providing IUD insertion. While respondents from Beni-Suef demonstrated non acceptance for the eligibility of nurses to conduct IUD insertion (81%), 44% of respondents from Menofia had approved the idea that nurses could be eligible for providing IUD insertion services.

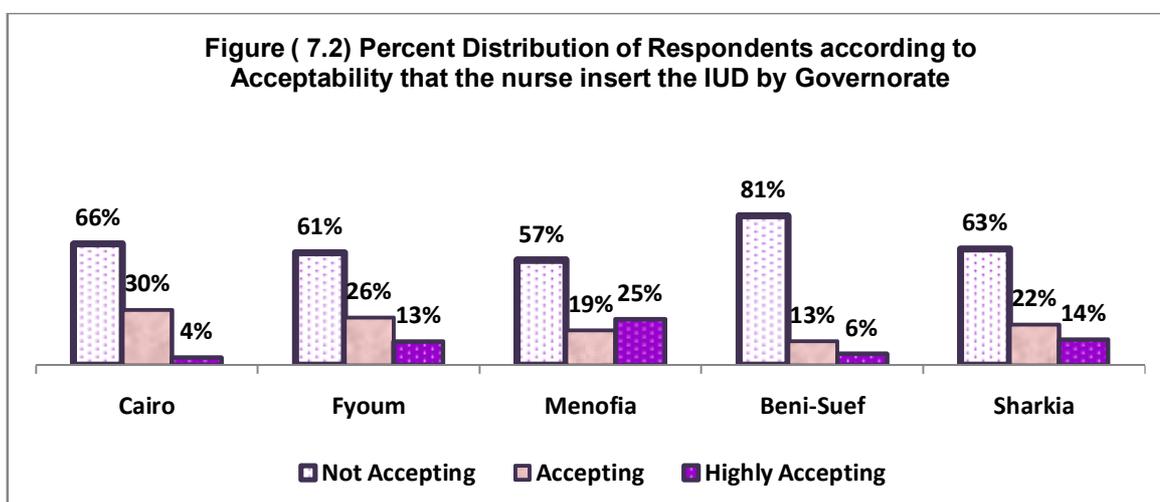


Figure (7.2) Percent Distribution of Respondents according to Acceptability that the trained nurse is eligible to insert IUD by governorate

Figure (7.3) shows the percent distribution of respondents according to acceptability that the trained nurse is eligible to insert the IUD by current job of the respondents. The figure demarcates the high objection rate expressed by male and female physicians (more than 70%) for the idea that the trained nurse is eligible to insert the IUD. However, there was

statistically insignificant variation across respondents with different jobs ($P=0.3$) regarding acceptability that the trained nurse could be eligible for providing IUD insertion.

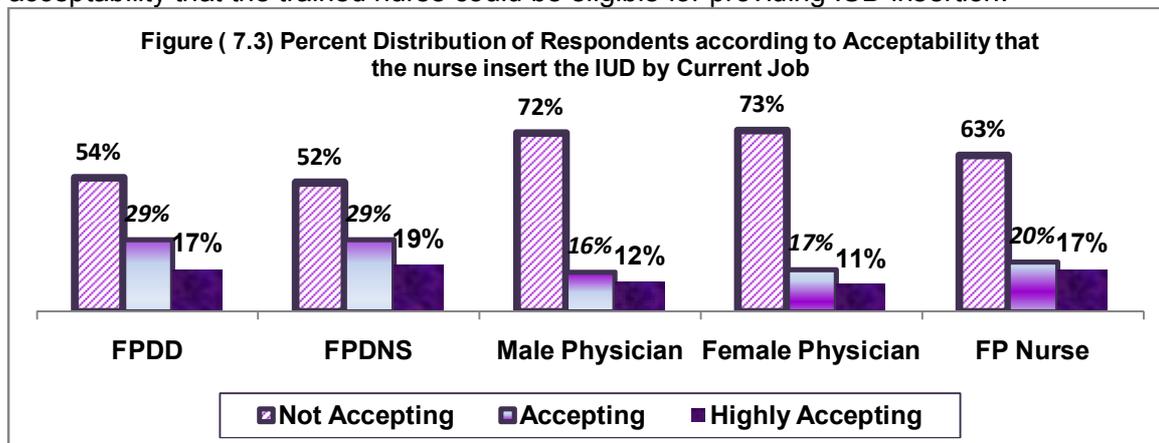


Figure (7.3) Percent Distribution of Respondents according to Acceptability that the trained nurse is eligible to insert IUD by current job of respondents

Figure (7.4) demonstrates the percent distribution of respondents according to acceptability that the trained nurse is eligible to insert the IUD by duration of work in FP services. The figure demarcates the high objection rate expressed by midlevel cohorts (those working in FP services for 1-<10 years (more than 70%) for the idea that the trained nurse is eligible to insert the IUD. Those who worked in FP for 20 years and more expressed highest acceptability rate for the idea that the trained nurse is eligible to insert IUD, compared to other cohorts. However, there was statistically insignificant variation across respondents with different duration of work in FP ($P=0.26$) regarding acceptability that the trained nurse could be eligible for providing IUD insertion

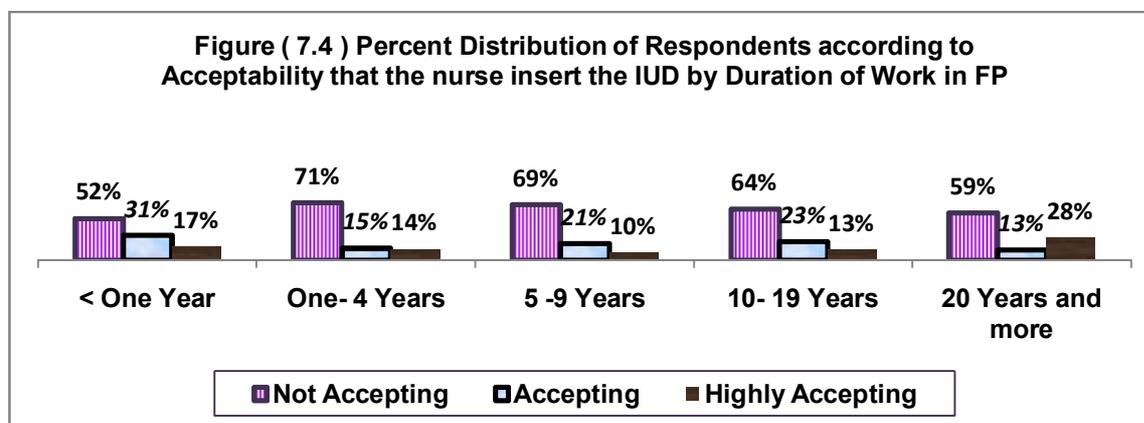


Figure (7.4) Percent Distribution of Respondents according to Acceptability that the trained nurse is eligible to insert IUD by duration of work in FP services

Figure (7.5) provides information about the views of those respondents delineated accepting that the nurse could be eligible for providing IUD insertion services. The figure demarcates two important eligibility criteria for nurses to provide IUD insertion services: Training of nurses worked in FP for more than 5 years (AS= 57%) and selecting young nurses (18-35 years old) for training (AS= 42%).

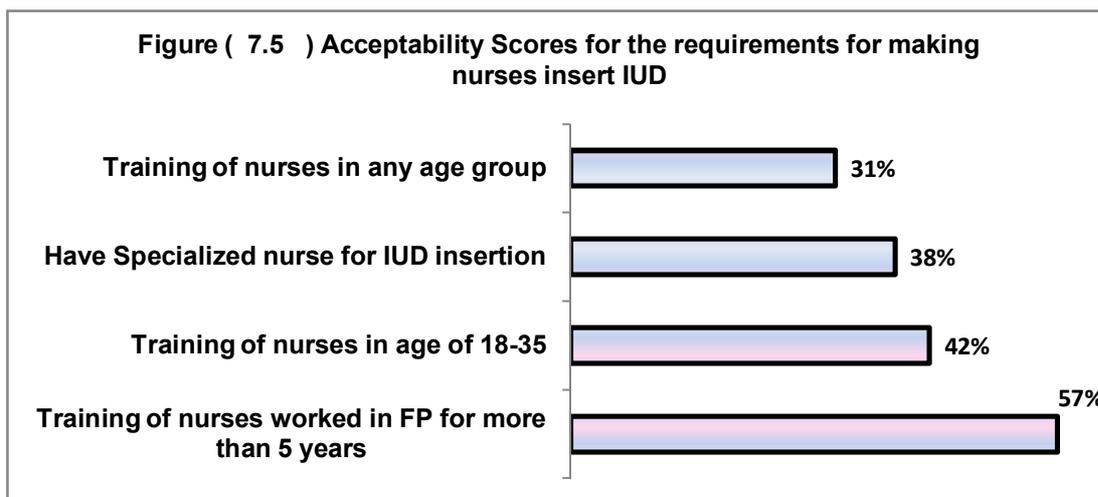
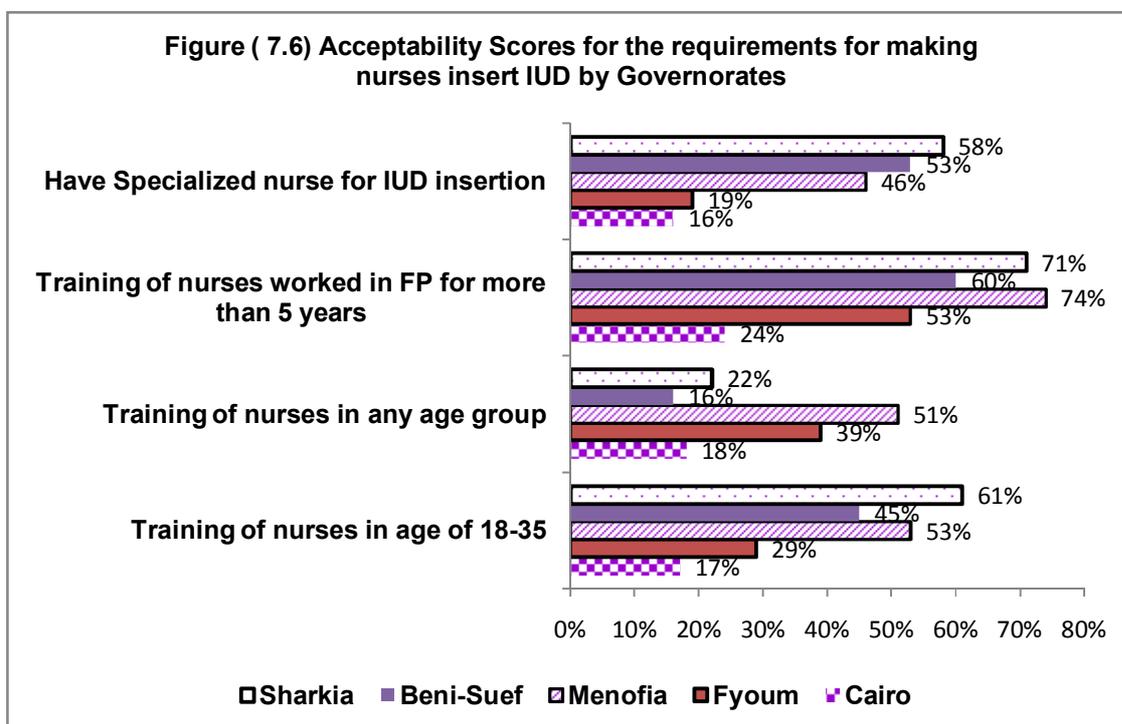


Figure (7.5) Acceptability Scores for the requirements for eligibility of nurses for IUD insertion as expressed by the respondents

Figure (7.6) displays information about the views of respondents who accepted that the nurse could be eligible for providing IUD insertion services by governorate. The figure demarcates that the two governorates who reported high AS for two eligibility criteria for nurses to provide IUD insertion services were Sharkia and Menofia: Training of nurses worked in FP for more than 5 years (AS= 74% for Menofia and 71% for Sharkia) and selecting young nurses (18-35 years old) for training (AS= 61% for Sharkia and 53% for Menofia).



Figure

(7.6) Acceptability Scores for the requirements for eligibility of nurses for IUD insertion as expressed by the respondents by governorate

Table (7.1) shows the views of respondents who accepted that the nurse could be eligible for providing IUD insertion services by governorate. The table shows that there is no consensus across the governorates regarding the eligibility criteria for nurses to provide IUD insertion services ($p= 00$) for the studied four criteria. Respondents from Sharkia supported the view of selecting young nurses (18-35 years old) for training (AS = 61%) versus those from Cairo (AS= 17%). Respondents from Sharkia supported the view of having specialized nurse providing IUD services (AS= 58%) versus those from Cairo (AS = 16%). Respondents from Menofia Governorate supported the training of nurses worked in FP for more than 5 years (AS= 74%) versus those from Cairo (AS= 24%). Training of nurses in any age group was supported by respondents from Menofia Governorate (AS= 51%) versus those from Cairo (AS= 18%).

Table (7.1)Acceptability Scores for the requirements for eligibility of nurses for IUD insertion as expressed by the respondents by governorate

Requirements to accept nurses for IUD insertion	Acceptability	Governorates						P
		Cairo	Fyoum	Menofia	Beni-Suef	Sharkia	Total	
Training of nurses in age of 18-35	Acceptability Level	17%	29%	53%	45%	61%	42%	0.008
	% of Non-acceptors	77%	63%	39%	50%	33%	51%	
	Total	88	65	89	44	104	390	
Training of nurses in any age group	Acceptability Level	18%	39%	51%	16%	22%	31%	0.000
	% of Non-acceptors	75%	52%	39%	80%	71%	62%	
	Total	87	65	90	41	92	375	
Training of nurses worked in FP for more than 5 years	Acceptability Level	24%	53%	74%	60%	71%	57%	0.000
	% of Non-acceptors	73%	34%	19%	36%	23%	37%	
	Total	88	67	95	42	94	386	
Have Specialized nurse for IUD insertion	Acceptability Level	16%	19%	46%	53%	58%	38%	0.000
	% of Non-acceptors	82%	76%	47%	44%	33%	57%	
	Total	88	63	81	43	91	366	

Figure (7.6) displays information about the views of respondents who accepted that the nurse could be eligible for providing IUD insertion services by current job. The figure demarcates that the requirement of training of nurses worked in FP for more than 5 years was supported by FP nurse (AS= 65%) male physicians (AS= 63%) and FPDNS (AS= 61%).

Table (7.2)demonstrates Acceptability Scores for the requirements for eligibility of nurses for IUD insertion as expressed by the respondents by current job. The table determines the level of consensus among respondents from different jobs for three items ($p>0.05$): selecting young nurses (18-35 years old) for training, having specialized nurse providing IUD services and Training of nurses in any age group. However, there was statistically significant difference across respondents from different jobs regarding the item of training of nurses worked in FP for more than 5 years, where some respondents reported highest AS, for example FP nurses (AS= 65%) and male physicians (AS= 63%).

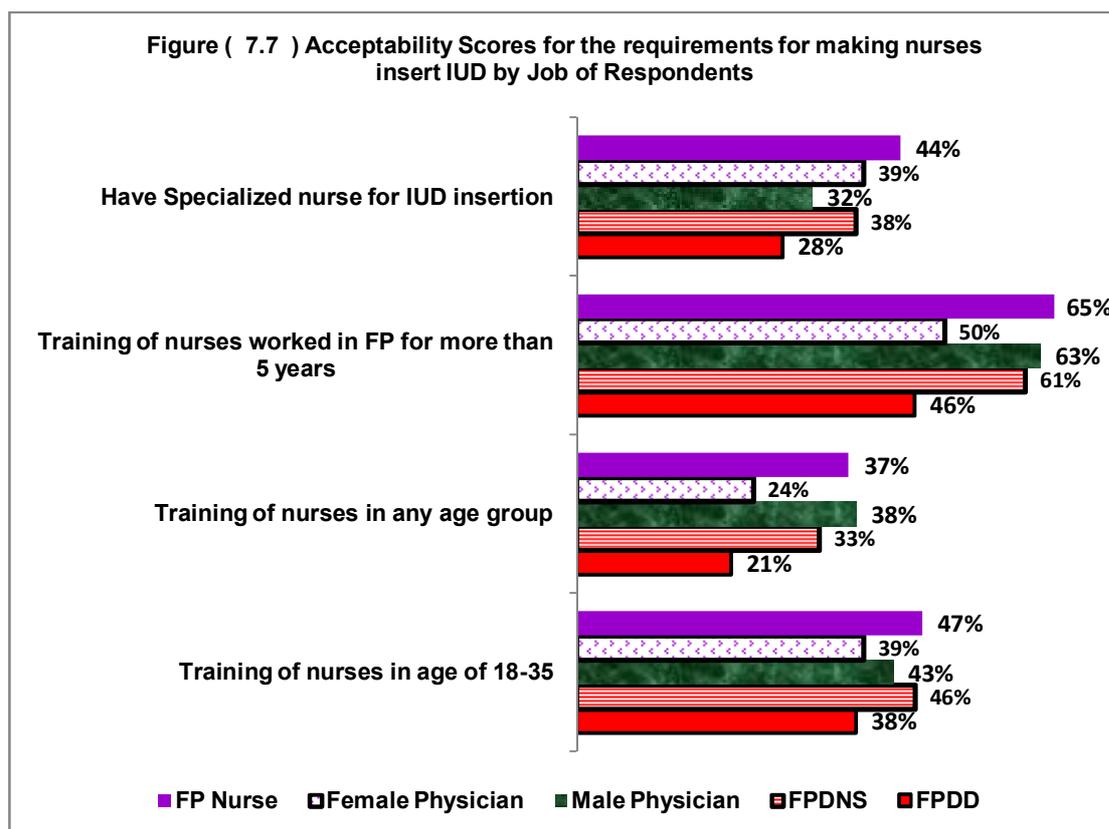


Figure (7.7) Acceptability Scores for the requirements for eligibility of nurses for IUD insertion as expressed by the respondents by current job

Table (7.2) Acceptability Scores for the requirements for eligibility of nurses for IUD insertion as expressed by the respondents by current job

Requirements to accept nurses for IUD insertion	Acceptability	Current Job of the Respondents					Total	p
		FPDD	FPDNS	Male Physician	Female Physician	FP Nurse		
Training of nurses in age of 18-35	Acceptability Level	38%	46%	43%	39%	47%	44%	0.7
	% of Non-acceptors	53%	49%	49%	55%	47%	50%	
	Total	43	49	43	77	150	362	
Training of nurses in any age group	Acceptability Level	21%	33%	38%	24%	37%	32%	0.1
	% of Non-acceptors	71%	57%	51%	70%	56%	60%	
	Total	38	47	41	79	141	346	
Training of nurses worked in FP for more than 5 years	Acceptability Level	46%	61%	63%	50%	65%	59%	0.03
	% of Non-acceptors	48%	36%	28%	44%	27%	34%	
	Total	40	47	40	82	146	355	
Have Specialized nurse for IUD insertion	Acceptability Level	28%	38%	32%	39%	44%	39%	0.07
	% of Non-acceptors	63%	59%	63%	54%	51%	56%	
	Total	38	49	38	72	140	337	

Figure (7.7) presents information about the views of respondents who accepted that the nurse could be eligible for providing IUD insertion services by respondents' duration of work in FP services. The figure demarcates that the requirement of training of nurses worked in FP for more than 5 years was supported by those worked in FP services for 20 years and more FP nurse (AS= 64%) and the very young cohort who worked in FP for less than one year (AS= 62).

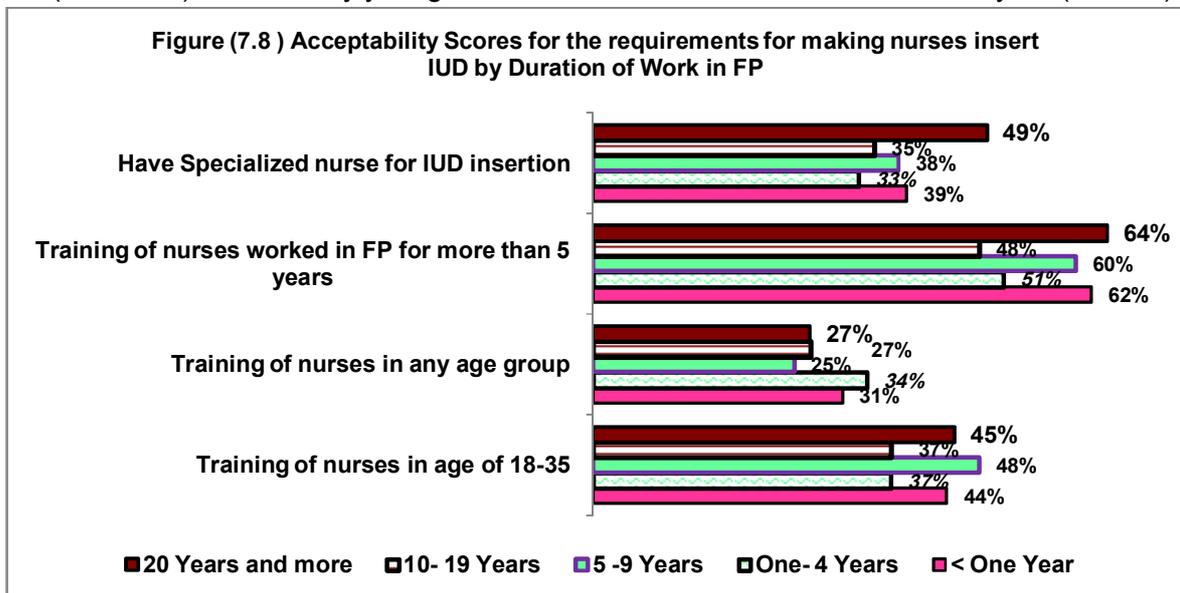


Figure (7.8) Acceptability Scores for the requirements for eligibility of nurses for IUD insertion as expressed by the respondents by duration of work in FP services

Table (7.3) highlights Acceptability Scores for the requirements for eligibility of nurses for IUD insertion as expressed by the respondents according to the duration of work in FP services. The table determines the level of consensus among respondents from different cohorts for the four items ($p > 0.05$) related to the suggested criteria for eligibility of nurses for IUD insertion.

Table (7.3) Acceptability Scores for the requirements for eligibility of nurses for IUD insertion as expressed by the respondents by duration of work in FP services

Requirements to accept nurses for IUD insertion	Acceptability	Duration of Work in FP Program					Total	p
		< One Year	One- 4 Years	5 -9 Years	10- 19 Years	20 Years & more		
Training of nurses in age of 18-35	Acceptability Level	44%	37%	48%	37%	45%	41%	0.69
	% of Non-acceptors	51%	55%	45%	57%	49%	52%	
	Total	39	76	87	118	41	361	
Training of nurses in any age group	Acceptability Level	31%	34%	25%	27%	27%	29%	0.47
	% of Non-acceptors	62%	56%	70%	66%	64%	64%	
	Total	42	72	80	112	39	345	
Training of nurses worked in FP for more than 5 years	Acceptability Level	62%	51%	60%	48%	64%	55%	0.36
	% of Non-acceptors	30%	44%	33%	46%	29%	38%	
	Total	44	73	86	112	41	356	
Have Specialized Nurse for IUD insertion	Acceptability Level	39%	33%	38%	35%	49%	37%	0.37
	% of Non-acceptors	56%	63%	57%	59%	44%	57%	
	Total	39	67	83	112	39	340	

Qualitative Data

The qualitative data were collected through in-depth interview with MOHP/PS HQ and FGDs with FP directors in the five governorates and FGDs with the nurse supervisors working in the same governorates. The qualitative data had been analyzed according to the seven key issues of the current study.

■ The observed increase in proportion of OCs clients:

Almost all the participants affirmed the observation that during the last 5 years, there was progressive increase in the proportion of OCs clients. MOHP/HQ staff referred this observation to governorates' requests for progressive increase the amount of Microcept pills over time. MOHP staff from the studied governorates highlighted the issue of true increase in the proportion of OCs clients in MOHP/FP clinics as recorded in the service statistics. However, MOHP Governorate staff considered that the indicator measuring their performance is the contraceptive coverage rate. This rate could be kept constant by increasing in OCs users when there are no enough IUD clients.

However, the MOHP/HQ raised important issue about the increase in use of combined OCs which could increase the CCR. However, the increase in use of combined OCs have many shortcomings that have negative effect on the program that has the goal of increasing contraceptive use to improve women's and children's health. One important issue is related to using combined OCs by lactating women (which should be investigated) could reduce breast feeding practices with subsequent high children morbidity and mortality. Additionally, the use of combined OCs which is kept under control of the women, increase susceptibility to discontinuation and increase the unwanted pregnancy and its subsequent misbehavior as unsafe abortion.

■ Factors contributing for FP method shift towards OCs

The participants pointed to that clients' choice to OCs is pivotal for formulating the pattern of shift from one method to another.

FPDD-Sharkia Governorate raised the issue of improvement in the quality of client's usage of OCs. Instead of using OCs at the day of intercourse, the woman use OCs on-daily bases irrespective to the marital relations. Consequently, women's demands for OCs packets are increasing.

The participants had described the situation in MOHP/FP clinics that constitute a driving force for women to shift towards OCs. Throughout the period of foreign donor –supported FP projects, the physicians and nurses were fascinated to work in FP program. The surplus of resources and the presence of legislations to get incentives from the fund raised from

dispensed contraceptive methods were motivating for service providers to work in FP services. Additionally, the well-designed practical training in FP was very attractive for the new generations of physicians. Currently and after phasing out of the foreign donation support, and cancelling the incentive legislation and decreased the quality of training, physicians became no more interested to work in FP. Therefore, the physicians have the sense of unsatisfactory skills in IUD insertion. Physicians become no more interested to upgrade their performance in IUD insertion and to carry the risk of IUD insertion, while, there is alternative way to provide the service of FP through dispensing OCs.

This situation had made MOHP/FP clinics work as pharmacies for dispensing OCs, rather than providing quality FP services that is based on proper counseling and discussing the cafeteria of FP methods to clients, to build up the informed choice for FP methods.

■ **Why Clients prefer OCs:**

The participants affirmed that women became highly oriented about different FP methods regarding use, side effects, the needs for gynecological examination and follow up. Consequently, women build up their decision for using OCs based on the fact that “the use of OCs satisfies the women’s autonomy in selecting and using the method. OCs use satisfies the concept of “independence” during selection and use of the method at any time and for any period. Other methods as IUD need both gynecological examination and follow up and management of side effects as bleeding. Injectables need the nurse for the three-monthly injection. Condom use needs cooperative husband. Implanon needs trained qualified physician for Implanon insertion and removal, as well as Implanon is not available all the time in MOHP/outlets of service delivery.

■ **leakage of OCs from MOHP FP-Clinics to other outlets**

The FP directors and nurse supervisors delineated that they respond to increasing requirements of the clinics to Microcept. They attributed the increased requirements to Microcept to shortage of availability of Microcept in private pharmacies. Consequently, private pharmacy clients had shifted towards MOHP clinics to get the Microcept which is usually available in MOHP/FP clinics.

However, MOHP/HQ staff ascertained that Microcept is distributed to private pharmacies, and no shortage in Microcept supply to pharmacies. Therefore, the causes of shift towards OCs use could be due to changes in the pattern of service delivery in MOHP/FP clinics that motivate women to use OCs, and/ or invisible leakage of OCs through over- recording of OCs use as dispensed Microcept to clients rather than true users of the method. Thus, auditing at the clinic level that includes review of the clients’ form and the amount of dispensed method could

investigate the leakage process, if it is there and it is in this point of logistic management cycle for contraceptive commodities.

■ **Causes of shift from IUD to OCs**

The participants went through a brain-storming activity to deal with the issue of shift from IUD to OCs use. The raised issue was related to the contraceptive technology of IUD and dynamics of use. After declaration of WHO that IUD could be inserted and to remain in the uterus for ten years and more, women do not have to shift to another method. Therefore, IUD users become continuing users without reporting to those who are interested in FP program. However, OCs users/continuers carry on visiting the FP clinics to get the method on-monthly basis and recorded as return visit users for OCs.

The issue related to the new young female generations who added new cohorts of women in the child bearing period raises many inquiries about the pattern of contraceptive use. The new FP users could be interested to use OCs rather than IUD for different personal and fertility reasons or they did not find a service provider to guide them for informed choice to other long term method as IUD.

■ **Capitalizing on physicians to increase IUD use**

The participants focused on two important disputes; the incentives and the training systems. Incentives to physicians to provide the IUD insertion services are of the pivotal issues. The physicians are looking for training that fulfill the quality standards, and build the trustable skills in IUD insertion. The attentiveness towards good training and acquiring skills in IUD insertion delineates that those skills are essential to be practiced in public sector to get experience and to provide this service in private clinics with good quality to keep good reputation. However, the current training in FP is not enough to satisfy the needs of physicians. Additionally, the high turnover, and thinking about the professional career had made thinking about capacity building in FP become no more appreciated.

■ **Acceptability of having a role of trained nurse in IUD insertion.**

The participants from MOHP/PS and FP nurse supervisors had demonstrated interest to build the capacity of nurses to provide IUD insertion services. They claimed that nurses are currently included in the midwifery training program which is more difficult and risky practice than IUD insertion. Additionally, in some of the FP clinics, the nurse – behind the seen- successfully provides the service of IUD insertion compared with the non-trained physician.

However, some participants raised the issue that the nursing legislation forbids the task of IUD insertion to be within the job description items of FP nurse. However, testing this intervention is needed before advocacy for making nurses perform the task of IUD insertion.

CHAPTER 5: CONCLUSION AND RECOMMENDATIONS

Conclusion:

The study concluded that there are three articulating issues that lead to shift from IUD to OCs: The unsatisfactory **training** and **incentive** systems for service providers and the **clients' choice** of OCs for independent use/autonomy without the need of provider's services.

Recommendations:

(1) Activation of the FP Clinical Supervision Teams:

- The FP clinical supervision team has to visit the health facility with background information about the performance of the FP regarding the volume of utilizers and FP method mix pattern as derived from the MIS at district level
- Revising the MIS data before conduction of the supervision visit could help in identifying shortcomings in performance that could lead to method shift
- On-job training to service providers is crucial for continuous capacity building and resolve the problem of high turnover rate of doctors participated in the regular training
- Clinical supervision team has to devote efforts to establish continuous communication between service providers in the health facilities and the district hospital. The hospital should work as a reference and resource center to health facilities for training and reception of cases with FP side effects that need secondary level of care.

(2) Motivation of Service Providers to Provide Quality FP Services

- The interaction between the service providers and the clinical supervisors could build motivation for improving performance
- Redesign an incentive system as quality performance-based incentives, and the sources of those incentives are the fund accumulated from clients' payment for the FP methods
- Regular mobile teams' visits to FP clinics to provide IUD services by gynecologist,

(3) Upgrading the Training in FP Practice

- Remodel the training program for PHC physicians that is aiming at skill development in counseling and IUD insertion
- Motivation of physicians who presented a good demonstration to the acquired skills as IUD insertion to 5 women

- Redesign the pre-service training to focus on crucial skills rather than theoretical lectures. A special logbook could be used to ensure that the trainee had inserted 5 IUDs during the training

(4) Strengthening the Auditing System for FP Services

- Logistic management system should consider both the distribution system and the dispensing pattern of contraceptive method mix
- Periodic investigation and collecting information from MIS, pharmacies, clients and service providers to explain and justify any deviation from the FP method mix pattern of MOHP clients
- Periodic reporting on FP methods distributed and FP methods dispensed and compare the situation over different periods of time for appropriate intervention
- Contribution of the pharmaceutical companies and MOHP in discussion/dialogues related to method shift to identify the major causes

(5) Proper Utilization of MIS for Timely Decision-Making

- MOHP/PS MIS has to develop indicators that facilitate diagnosis of any issue related to FP clinics' utilization.
- Introduction of efficiency and effectiveness indicators in MIS to identify the governorates that have major issue in FP clinics' performance
- Use of indicators as FP method shift Index, New to return visits ratio, New FP clients to continuing FP clients ratio
- Redesign the MIS formats to link between age of the last child and method used. Such information is crucial to ensure using the suitable method by lactating women

(6) Conduct Future Studies to Provide Evidence-Based Decisions

- Evaluation of counseling through exit interview with FP clients
- Study the duration of use of IUD by MOHP clients
- Study the utilization pattern of different FP methods throughout the reproductive cycle of women
- Reasons of FP method shift and its pattern among FP method users and discontinuers-community based study.

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Annex: Questionnaire Form



وزارة الصحة والسكان / قطاع السكان
مشروع تأمين وسائل تنظيم الأسره

رقم الإستماره □□□

إستبيان

أسباب التحول الى زيادة استخدام الحبوب الفميه
وتناقص استخدام اللولاب في عيادات تنظيم الأسره
بوزارة الصحة والسكان ٢٠٠٧-٢٠١٢

البيانات تستخدم لأغراض البحث العلمى فقط ولا تحتوى الاستماره على أى بيانات شخصيه

سبتمبر ٢٠١٢

استبيان خاص بآراء الأطباء والممرضات العاملين فى
مجال تنظيم الأسره

مقدمه : للأطباء والممرضات

الزميلات والزعماء الأعزاء :

لقد حققت وزارة الصحة والسكان نجاحا ملحوظا في برنامج تنظيم الأسرة حتى أصبحت المصدر الأول والأساسى للوسائل والخدمات ذات الجودة ، ومن خلال إحصاءات الخدمه ٢٠٠٧-٢٠١١ وجد أن هناك زياده فى نسبة السيدات المتزوجات فى سن الإنجاب تصل الى ٩,٨% وقد واكبها زيادة المنتفعات بخدمات تنظيم الأسرة بوحدهات وزارة الصحة بنسبة تصل الى ٣٩% فى نفس الفتره ، إلا أنه قد لوحظ أن هناك زياده كبيرة فى نسبة السيدات المستخدمات للحبوب الفميه وهناك نقص فى نسبة السيدات المستخدمات للوالب ، وكان هناك تباينات بين المحافظات لنسب تحول المنتفعات من اللوالب الى الحبوب الفميه . لذلك يقوم مشروع تأمين وسائل تنظيم الأسرة بالتقصى عن أسباب هذه الظاهره وذلك لإتخاذ الإجراءات التى من شأنها أن تساعد فى اعاده التوازن فى توليفه الوسائل التى تقدم للمنتفعات بخدمات تنظيم الأسرة

إن إجاباتك عن التساؤلات المقدمة سوف تكون عوننا لنا للوصول إلى أسباب التغيرات فى توليفه وسائلتنظيم الأسرة - والذى يحدث حاليا فى وحدات وزارة الصحة والسكان - وبذلك نستطيع معا الوصول الى حلول ايجابية من أجل توفير الوسائل المناسبه للمرأة المصريه وبجوده وفاعليه مرضيه .

هل توافق على المشاركة فى الدراسه بأرائك ؟

١- نعم	٢- لا
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أولا - بيانات تعريفيه

١-١	محافظه :
٢-١	اداره :
٣-١	العمل الحالى :
	١- مدير اداره تنظيم الأسرة
	٢- مشرفه تمرىض
	٣- طبيب مركز صحى / وحده صحيه
	٤- طبيبه مركز صحى / وحده صحيه
	٥- ممرضه مركز صحى / وحده صحيه
	مدى العمل فى تنظيم الأسرة بالسنوات

ثانيا : رؤيه مقدموا الخدمه فى التحول من اللوالب الى حبوب منع الحمل

١-٢	هل لاحظت أثناء عملك أن هناك زياده فى الإقبال على الحبوب الفميه؟	١- نعم ٢- لا
٢-٢	فى حالة وجود ظاهره التحول الى الحبوب الفميه (وكما أثبتت الإحصاءات) فمن يكون له الدور الأكبر فى ذلك؟	٣-موافق جدا ٢- موافق ٠-غير موافق
	[١] المنتفعات	
	[٢] الطبيب	

				[٣] الممرضة	
				[٤] الرائدة الريفيه	
				[٥] نظام الحوافز	
				[٦] نظام طب الأسرة	
				[٧] نظام توفير الوسائل	
				[٨] نقص التدريب	
				[٩] قصور الإشراف المركزى	
				[١٠] قصور الإشراف على مستوى المحافظة	
أخرى تذكر					
ثالثا - دراسة اتجاهات الطلب على وسائل تنظيم الأسرة بالوحده الصحيه					
١/٣	حاليا تقبل السيدات على الحبوب الفميه للأسباب الآتيه:	موافق جدا	موافق	غير موافق	
	[١] توافر الحبوب بالوحده الصحيه دائما				
	[٢] يمكن الحصول عليها دون كشف				
	[٣] لا توجد آثار جانبيه				
	[٤] سعرها مناسب				
	[٥] التحكم فى الإستخدام من قبل السيده				
	[٦] أخرى تذكر				
٢/٣	هناك بعض المصروفات تزيد التأكد منها فهل تتفق معنا فى:				
	[١] تسرب الحبوب الفميه من الوحدات الى الصيدليات				
	[٢] تسرب الحبوب الفميه من الوحدات الى جهات أخرى				
أخرى تذكر					
٣/٣	أسباب تحول السيده من اللولب للحبوب الفميه (كإجراء يقوم به الطبيب)	موافق جدا	موافق	غير موافق	
	[١] التدريب العملى غير كاف للطبيب لتركيب اللولب				
	[٢] الطبيب لا يجيد التصرف فى حالة حدوث أضرار جانبيه				
	[٣] لا توجد حوافز للطبيب فى حالة تركيب اللولب				
	[٤] اللولب يحتاج لمتابعه				
	[٥] يأخذ وقت أطول من الطبيب				
	[٦] يرى البعض أن قيام الطبيب بتركيب اللولب يتنافى مع حقوق المنتفعه فى إختيار وسيله أخرى				
	[٧] أخرى تذكر				
رابعا : رؤية مقدمى الخدمه لزيادة استخدام اللولب كوسيله أكثر فاعليه					
١/٤	ما رأيك فى المقترحات الآتيه والتي تتعلق بالطبيب	موافق جدا	موافق	غير موافق	
	١- تدريب الأطباء ويعطى شهاده بعد تركيب ٥ لولب على الأقل				
	٢- حوافز ايجابيه للطبيب الذى يقوم بتركيب اللولب طبقا للمشوره ذات الجوده				
٢/٤	ما رأيك فى قيام الممرضة بتركيب اللولب بعد التدريب ؟				
٣/٤	فى حالة الموافقه على قيام الممرضة بتركيب اللولب :	موافق جدا	موافق	غير موافق	
	١- تدريب الممرضة فى الفنّه العمريه ٣٥-١٨				
	٢- تدريب الممرضة فى أى فنّه عمريه				
	٣- تدريب الممرضة التى عملت فى تنظيم الأسره لأكثر من ٥ سنوات				
٤/٤	مقترحات أخرى لتحقيق التوازن فى توليفه وسائل تنظيم الأسره :				
	(١)				
	(٢)				

