Original article

Community-based Family Planning services: A performance assessment of the Jimma FP CBD project

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Abstract: Community Based Distribution (CBD) programs reach beyond the clinic walls to provide contraceptives in the communities where people live. The ultimate goal of CBD programs is to improve the accessibility of contraceptive services and supplies. In view of this, the Family Guidance Association of Ethiopia (FGAE) has recently intiated CBD programs in some rural areas. The aim of this study is to assess the overall performance of the Jimma CBD project with respect to achieving the set objectives and measure the changes that have occurred in the levels of knowledge and use of family planning methods among the eligible couples. Results of the study showed, that the knowledge of women about contraception appeared to be higher (76.9%) than the proportion reported in the baseline survey (36.9%). Comparing the contraceptive prevalence rate of 1.3% reported in the baseline survey, the rate reported in this study is found to be substantial (15.9%). Generally, the project achievement enlisted in the period of 21 months of operation was found to be impressive. Thus, replication of the program in other rural areas should be sought. [*Ethiop. J. Health Dev.* 1997;11(1):17-22]

Background

In developing countries, family planning services are delivered mainly through health institutions. In the African context, the majority of the population does not have similar privileges of ease of access to facilities for family planning service delivery, especially in rural areas. Though in some countries clinic-based family planning service delivery facilities exist, these services are far from being adequate to meet the needs of the population demanding such services, (1).

The introduction of modern family planning services in Ethiopia dates back to 1966, when the Family Guidance Association of Ethiopia (FGAE) was founded as a non-governmental and not-forprofit organization to provide information, counselling and clinical services to families who voluntarily express their need and desire for spacing the birth of their children.
when the Ministry of Health integrated family planning with the Maternal and Child Health care (MCH) services in 1980. Since then, family planning services have been offered through government static health institutions and other organizations. This approach, which has been clinicbased and biased towards curative medicine, has remained remote from the potential and large segment of family planning users residing in rural areas.

To make family planning information and services accessible and affordable to the hard- to-reach rural communities, community-based distribution (CBD) programs have been practiced in many developing countries and this approach brought about successful results in Asian and African countries. In view of this fact, expansion of community-based distribution of family planning

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The services have been further strengthened

"The Jimma Family Planning Community- Based Distribution Project", funded by Population Concern (UK), is serving rural communities of "Mana and Kersa" woredas of Jimma zone, around Jimma town, South West of Ethiopia. The project is designed to expand family planning services through increased knowledge of family planning concept by promoting accepted contraceptive mix

services is indicated as one of the basic implementation strategies in the National Population Policy of Ethiopia launched in July 1993, (2).

with community participation. Specifically, the project is aiming at increasing knowledge of family planning among the couples from the observed 36.9% to 75% and raising the contraceptive prevalence rate from 1.3% to 15% in the period of three years (3).

With these specific objectives the project had been in operation for about 21 months. Thus, this mid term review has become imperative to assess its achievements with respect to attaining the intended objectives and to identify the major constraints that hinder project performance.

This study tries to assess the overall performance of the Jimma CBD program during the 21 months it has been in operation, and to identify the strong and weak points of the program.

Specifically, the objectives are to:-

i) measure and compare the level of knowledge and use of family planning of the eligible couples with that of the baseline survey conducted prior to the program of intervention;

ii) assess to what extent the objectives of the project have been achieved.

Methods

Data for the analysis have come from three sources. A survey was carried out in April, 1994 to measure the levels of knowledge and practices of family planning of the community. It was undertaken in five randomly selected project sites, namely, Doyo Awaso, Gerukie Jimatie, Kitimbilie, Somodo Abujedi and Kersa Balto. These sites were the areas where the baseline survey of the project was carried out.

It is, however, worth to mention the differences in sampling methodologies of the two surveys. For the baseline, data were collected from all eligible women residing in the five project sites, while a sample of eligible couples have been randomly selected for this study. To this effect, it was planned to interview a sample of 225 couples, and about 98% of the intended respondents were successfully interviewed. The sample size was determined with critical considerations of cost and logistical feasibility. Thus, 10% of the eligible couples residing in the selected areas were taken. Samples were allocated to each survey site using probability proportional to size, proportion being the size of total eligible couples in each site. A Systematic sampling technique was then employed to select couples for interview and structured questionnaires were administered by enumerators. Service providers (CHAs) were also interviewed and further, records of the project were reviewed.

Results

The data on background characteristics of the interviewed respondents indicate that women in the age of 25 to 29 years constitute

Table 1: **Percentage distribution of Respondents Knowledge about Contraceptives by Method, 1994**

	Mid-Term		Baseline
Methods	Female (216)	Male (197)	Female (1447)
Pills	95.1(158)	91.2(125)	95.1(508)
Condom	13.8(23)	49.6(68)	13.8(74
Foam Tablet	7.2(12)	8.7(12)	7.5(40)
Injectable	13.8(23)	19.7(27)	25.8(138)
IUD	4.8(8)	4.4(6)	15.3(82)
Total	76.9(166)	69.5(137)	36.9(534)

N.B. Figures in parenthesis are number of cases

Table 2: **Distribution of Respondents Reporting Ever Use of Contraceptives by Method, 1994**

Methods	Mid-Term		Baseline
	Female(220)	Male (210)	Female (1409)
Pills	96.0(48)	71.4(25)	96.8(60)
Condom	4.0(2)	22.8(8)	
Injectable	2.0(1)	2.9(1)	
IUD	-	-	3.2(2)
Total	22.7(50)	16.7(35)	4.4(62)

N.B. Figures in parenthesis are number of cases

the largest portion than women of other age groups. For the case of interviewed men, however, most are found at the age of above 50 years. With the mean age of 32.4 years, women are found to be younger by about 8 years than men. Further, respondents of the study area are predominantly muslim with low educational attainment. Of the total interviewed women, about 73% are illiterate and this proportion is small for the case of men.

The study also showed that the areas under investigation are characterized by high fertility. The reported total fertility rate (TFR) is estimated at 10.9 children per woman and both women and men want to have about three additional children.

Knowledge of respondents about health posts (service delivery points of the project) showed that women knew and visited the health posts more than men. In conjunction with this, the study revealed that the knowledge of women about contraception appeared to be higher (76.9%) than the proportion reported in the baseline survey (36.9%) (4). A substantial number of them (about 95%) have heard about the pills. The level of men's knowledge about contraception is also found to be high with 69% of them reporting that they have heard at least one method of contraception (Table 1). A good number of women (72.1%) and men (65.5%) stated that their sources of information were the CBD agents.

With regard to the use of contraception, the study showed that a significantly higher proportion of ever use (22.7%) is reported among women than ever use reported in the baseline survey (4.4%), (4) and a considerable number of them have used pills (Table 2).

As to the level of current use, about 16% of women and 13% of men were using contraceptive method at the time of the survey. Comparing the contraceptive prevalence rate of 1.3% reported in the baseline survey, (4) the rate reported in this study is noticeably high. As expected, the prevalence of pills is high, about 94.4% of current users were using the method (Table 3) and health posts are mentioned by almost all ever users (about 94%) as the main source of contraceptive supply.

Table 3: **Distribution of Current contraceptive Users by Method, 1994**

Methods	Mid-Term		Baseline
	Female(220)	Male (220)	Female (1338)
Pills	94.4(38)	89.3(25)	90.0(18)
Condom	-	3.6(1)	
Injectable	2.8(1)	3.6(1)	
IUD	2.8(1)	3.6(1)	
Total	-	-	10.0(2)

N.B. Figures in parenthesis are number of cases

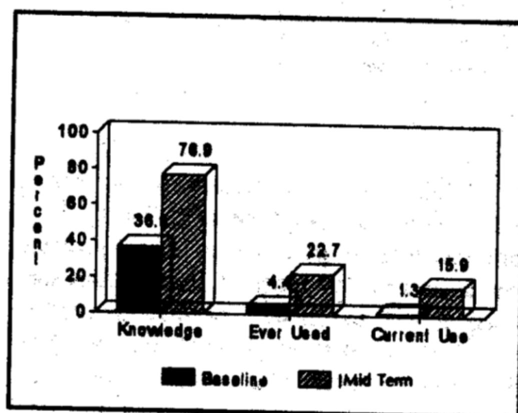

Figure 1: Percentage of Women heard about, ever used and current use of FP method

It is also observed that, among non-users, desire for more children is frequently mentioned as the reason for not practising contraception. In the baseline survey, however, lack of knowledge about family planning was the most frequently mentioned reason for not practising contraceptives (Table 4).

The analysis further revealed that both the CBD agents and the family planning educator assigned to the project, jointly motivated, on the average, 6,700 people residing in all CBD. Accordingly, teaching aid materials (2510 leaflets, 710 booklets and 2346 posters) dealing with different family planning messages have been distributed to support the motivational endeavors.

Table 4: **Distribution of Never Users by Reasons for Not Using Contraceptives, 1994**

Reasons	Mid Term		Baseline
	Female (161)	Male (163)	Female (1347)
Naturally Spaced	13.6(22)	9.1(15)	
Desire for more children	37.0(60)	50.6(83)	19.3(260)
Do not want to use	19.8(32)	17.1(28)	0.5(7)
Infertility	14.2(23)	10.4(17)	8.8(119)
Lack of Knowledge about FP	11.7(19)	11.0(18)	67.5(910)
Husband's Opposition	1.2(2)	-	11.3(152)
Health Concern	1.9(3)	0.6(1)	4.9(66)
Religious Reason	-	0.6(1)	3.5(47)

N.B. Figures in parenthesis are number of cases

Table 5: **Contraceptives Issued and CYP Generated, July 1992-March 1994**

Contraceptive Method	Unitq	Issued	CYP Generated
Pills	Cycles	11277	867
Condom	10955	110	

Foam Tablet	119	24	
Total			1001

Additionally, the records of the project indicated that a total of about 11,300 cycles of different types of pills, about 11,000 pieces of condoms and 119 tubes of foam tablets have been issued to clients. In this connection, Couple Year of Protection (CYP), one of the measures of family planning program output, (5) is calculated, and found that a total of 1001

Table 6: **Percentage of Contraceptive Acceptors by Method, July 1992-March 1994**

Method	Acceptors	
	New	Revisit
Pills	69.6(1348)	96.0(9523)
Condom	27.4(530)	3.6(<358)
Foam Tablet	3.0(< 58)	0.4(<41)
Total	100.0(1936)	100.0(9922)

NB Figures in parenthesis are number of cases

CYP was achieved within the period of 21 months (Table 5). In other words, within a period of 21 months, a total of 1001 couples were protected from pregnancy in the project areas due to the program intervention. With regard to contraceptives acceptors, a total of 1936 new and 9922 acceptors were served, and the majority appeared to be pills acceptors (Table 6).

Discussion

Twenty two trained community health agents (CHAs) are the principal distributors of contraceptives in 23 project sites. All the agents except one are males,and have a mean age of about 33 years. About 44, 39 and 17 percent of the interviewed agents had attained primary, junior and secondary schooling, respectively, and all are found to be married. The activities of the CBD agents are supervised by six trained health assistants. One health assistant, on the average, supervises four CBD agents.

The CBD agents, responsible for the motivational and contraceptive distribution activities, motivate the eligibles on family planning at group meetings and through home visits. As to service delivery, the agents distribute contraceptives such as oral pills, condom and foam tablets through the health posts and home visits.

Steering committees at different levels vis, peasant associations, at woreda and regional levels, have been established to enhance community participation for effective implementation of the program. These committees held meetings on quarterly basis. Particularly, the steering committee formed at regional level assesses the overall project performance as well as the budget utilization of the project. It also provides solutions for problems the program encountered during implementation. This study shows age difference of about eight years between spouses. This difference, although not significant compared to some other African countries, may create communication gap in discussing issues pertaining to family planning and fertility.

One frequently cited barrier to more widespread adoption of family planning in some societies, especially among muslims is the religious opposition (6). Some studies, however, showed that muslims are pro-family planning services. This holds true for the case of Jimma CBD sites where about 97 percent of the sampled respondents are muslims.

Nearly three-fourths of the interviewed women know at least one method of contraception, with the pill as the most frequently (95.1%) mentioned method. The reported level of awareness about contraception is found to be higher by about two percent than the project target of 75%. Generally,

a significant increase (about 100%) in the level of awareness of women about contraception is achieved in contrast to the level reported prior to program intervention.

Concerning contraceptive use, proportions of ever and current users are estimated to be 22.7 and 15.9 percent, respectively. These proportions are substantial compared to the reported level (4.4 and 1.3 percent respectively) in the baseline survey (4).

Information on reasons for not using contraceptive methods seem to be important to devise an appropriate IEC and service provision strategies. Desire for more children, followed by disliking of contraception and infertility problems were some of the reasons cited for not using contraceptive methods in the study area. Husbands' opposition and religious reasons, which were mostly mentioned as the main reasons for not practicing contraception in many other areas, have not been considered as hindrances for family planning in the study sites.

In conclusion, the observed high prevalence of knowledge, ever and current use may be attributed to the family planning intervention program that is being implemented at the sites under investigation. If the estimated prevalence rates are accurate, it could be said that the project is successful with regards to providing family planning services compared to the targets set in the project document. Apparently no major constraints have been observed. Community-based distribution programs can effectively provide services and supplies to communities which otherwise would not have access to family planning services. Therefore, replication of the program in other rural areas should be sought.

For further achievement, it is recommended that:-

- The motivational efforts of the project be continued and strengthened to bring about attitudinal changes among the community towards small family norm with special emphasis to men.
- Films with a variety of family planning messages be made available to the project and be used on a regular basis.
- Since the communities of the study sites are characterized by high fertility, much has to be done to reduce the prevailing high fertility rate by effectively implementing the existing family planning program in the area.
- Consideration should be given to supply health posts with some basic drugs so that the agents would retain a portion from sales of the drugs. This will certainly encourage the CHAs to effectively carry out their duties.
- Sensitization seminars and orientations for influential and religious leaders be organized occasionally, specially at grassroots level, to secure and enhance their support to the program.

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