

Original Research Article

Access to and Utilization of Quality Family Planning Services: Challenges and Opportunities in Meeting FP2020 Targets

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ABSTRACT

Objective: This study aimed to explore the current challenges and opportunities in access to and utilization of family planning services in Ethiopia.

Methods: A multi-level study was conducted with a cross-sectional study design in quantitative and qualitative methods. Data were collected through survey with 1,354 mothers in reproductive age, interviews with 37 key informants, and 13 focus group discussions with family planning service providers, health college instructors and the mothers in reproductive age in Oromia region, Ethiopia. Phenomenological and case study designs were applied for in-depth understanding of major aspects of family planning services.

Results: Information about family planning methods was universal, with 98% of mothers confirming they heard of any one of family planning methods and the same amount knew a place to get the services; with health extension workers taking the leading role (75%) in disseminating information. However, family planning knowledge was limited (43%) and use of modern-contraceptives was 59%, with 55% mothers showing interest to have more children; of whom 78% plan to give birth within two years. All mothers had been influenced by religion not to use modern-contraceptives, with Muslims comprising 65% less likely to utilize as compared to Orthodox (AOR=0.35, 95%CI: 0.21, 0.60). Modern-contraceptives were accessible at health facilities, however; home-visit family planning coverage was low (23%). Family planning service providers had contraceptive clinical and counseling skill limitations while health colleges lacked demonstration materials.

Conclusion: Though the Ethiopian government has so far improved access to family planning services, utilization remained less, mainly due to limited family planning knowledge in the community, low home-based family planning coverage, and religious influences. Thus, meeting the FP2020 targets requires a high-level policy and political environment that would create skilled and well-motivated health workforces that can provide essential family planning knowledge and services to the community. In countries like Ethiopia, where people's religious devotion remains reasonably high, knowledge on natural-contraceptive methods is equally important to help religious people make an informed decision about family planning in accordance with their faith.

Key words: Family planning; contraceptive; FP2020; quality; religion; Ethiopia

INTRODUCTION

Over the past five decades, Ethiopia has been proactively responding to the Global call for accelerated efforts aimed at increasing access to and

utilization of quality Family Planning (FP) services that can empower people to make informed choices about the number and spacing of their children. The country has been striving to attain universal access to

reproductive health by the year 2015. Similarly, since July 2012, Ethiopia has been working intensely with other committed countries to meet the global FP2020 targets aimed at expanding contraceptive access to citizens. Reports of the 24th ordinary African Union Summit held in Ethiopia on the 28th January 2015 have testified Ethiopia's commitment to increasing FP-related budgets to address the needs of the rapidly expanding numbers of its young citizens. [1] According to the Central Statistical Agency of Ethiopia, [2] the use of modern FP methods has increased significantly as evidenced by the upward trend of the contraceptive prevalence rate from 8% in 2000 to 42% in 2015.

Despite all these efforts made and specific progresses counted, Ethiopia is lagging behind the Global FP goals and targets. The World Bank Group 2014 report indicates that total fertility rate in the country remains high at 4.5, [2] while the Central Statistical Agency (CSA) 2015 reports that adolescent birth rate is 63 per 1,000. On the other hand, the link between household and primary health care units hasn't been tied tightly to the required level. There have been limited standardized measurements for the different FP service indicators to serve as a basis for comparison at different levels of the health system.

Several studies have identified barriers to modern FP use, including limited knowledge/ awareness, misconceptions, fear of side effects from some methods, inadequate counselling, disapproval of FP use by men and community leaders, poor partner communication, the need to travel long distances on foot to access FP services, and unaffordable costs of these services in some settings, deprived referral coordination and unbalanced approach to program evaluation. [3-5] However, little was documented in Ethiopia.

The Ministry of Health of the Federal Democratic Republic of Ethiopia (FMOH) has been collaborating with different national and international implementing partners, such as the Ethiopian Public Health Association (EPHA), to improve FP services in the country. With financial support from the David and Lucile Packard Foundation, and in collaboration with the Amhara National Regional State, the Southern Nations, Nationalities and Peoples' Regional State health bureaus, and the Oromia Regional State health bureaus, EPHA has been supporting the health extension program to expand access to quality Reproductive Health/Family Planning (RH/FP) services for men and women, including young people. Currently, EPHA has developed a project to expand long-acting family planning services in the Oromia region and is implementing it in collaboration with the FMOH and the Oromia Health Bureau- this study was conducted as part of this initiative. The aim of this study was to explore the current challenges and opportunities in access to and utilization of FP services in Ethiopia in general and the Oromia region in particular. Specifically, the study has determined current level of FP services utilization, assessed the capacity of FP/RH leaders in terms of managing and leading quality and sustainable RH/FP programs, identified barriers to utilization of Long-Acting Family Planning (LAFP) services, determined training gaps on FP/RH of Midwifery and Clinical Nursing training institutions, and determined maternal health care seeking behavior.

MATERIALS AND METHODS

The study was conducted at community/household, health facilities, health bureaus, and Midwifery/Nursing training institutions in Oromia region in Ethiopia. A cross-sectional study design, with both quantitative and qualitative methods, was employed and the findings

triangulated. The quantitative part involves a cross-sectional community based survey. Contraceptive knowledge, perceptions and experiences of women related to FP service utilization as well as the accessibility of the services and performance of facilities to provide RH/FP services were evaluated. The qualitative part involves phenomenological and case study designs. In-depth analyses were conducted through key informant interview and focus group discussions to understand major aspects of FP services.

Community-based survey

For the community-based survey, the study population included all married women in reproductive age (15-49 years). Multistage sampling technique was used to select study participants. The entire EPHA project zones in the region, namely West Showa, East Wollega, West Wollega, Jimma and Illubabur were included. There were 99 districts (Woredas) in these five zones (West Showa =19, West Wollega = 21, Illubabur =24, Jimma =18 and East Wollega= 17). Considering logistic issues, time and geographical accessibility, Eight Woredas (one from Jimma zone, one from East Wollega and two from each of the rest zones) were selected randomly using proportional allocation. Two kebeles (the lowest administrative unit of Ethiopia) were selected from each Woreda randomly using equal allocation. Stratifying the kebele's into Urban and Rural, 16 kebeles (three from Urban and 13 from Rural) were included in the study. The total 1,354 respondents were included using single population proportion formula, and considering design effect of 1.5 and 10% non-response rate.

A semi-structured, pre-tested interviewer-administrated questionnaire was used for quantitative data collection at a household level. The questionnaire captures socio-demographic variables, reproductive and pregnancy history, fertility preferences, and knowledge about and utilization of respondents' family

planning service. Data collection manuals and interview guidelines were prepared and discussed with survey team members. For the qualitative data, discussions and interviews were recorded using a tape recorder and notes were taken after getting consent from the participants and interviews were conducted until a saturation point was reached.

Facility-based survey

The facility-based survey included District (Woreda) health offices, health centers, health posts, and midwife/nurse training institutions in 99 districts in the Oromia region, Ethiopia. Data were collected through two methods: In-depth interviews with 37 key informants (Health extension workers, health center heads, maternal and child health coordinators, zonal family health coordinators, Zonal and District health office heads, and deans of midwife/nurse training institutions), and three rounds of focus group discussions with FP service providers and instructors of medical colleges. Discussion points were used to guide the focus group discussions and in-depth interview with key informants. The guiding points were prepared to collect data related to skills in service provision, training service providers and RH/FP managers had, Midwifery/nursing training institutions on reproductive health/family planning course, and barriers of family planning service utilization.

Study variables

The independent variables were socio-demographic and economic factors (age, educational status, parity, ethnicity, economic status of the family, residence and occupation, and religion); knowledge of family planning services; and women's decision-making autonomy and spousal communication on FP whereas the independent variables were access to FP services, and utilization of FP services

Data processing and analysis

The association between potential factors and current utilization of

contraceptive methods was assessed using multivariate logistic regression model. A thematic content analysis approach focusing on the study questions was used for qualitative analysis of data from notes, interview forms, and records and quantitative and qualitative results triangulated. Data quality was assured through using adapted standard data collection instruments, conducting pre-testing for possible modifications, training of data collectors and pre-data collection idea exchange, enhancing privacy of respondents, and close supervision of data collection procedures.

Ethical clearance was obtained from EPHA and permissions from regional, Zonal, and Woreda health bureaus and training institutions. During data collection, study subjects were asked for oral consent and all necessary measures were taken to maintain confidentiality.

RESULTS

Quantitative findings

A total of 1,352 married women replied to the questionnaire. Fifty-three percent were aged 25-34, 68% lived in rural settings, and 50% have never gone to school and were unable to read and write. Forty-two percent of them followed Protestant Christian religion, followed by Orthodox Christian (30%) and Muslim (25%). About 45% of them were housewives and 33% farmers (Table 1). About half of them (51%) had 2 to 4 living children, 67.9% had one under 5 children, and 55% showed interest to have more children than they had of whom 78% planned to give birth within two years. Besides, 14.4% and 13.5% had faced abortion and still birth, respectively. Almost all (98%) had heard of any one of FP methods, particularly about injectables (99%), pills (94%), implants (88%), and Intrauterine Contraceptive Devices (IUCDs) (48%). In addition, 98% of them knew a place where they could get FP

methods. However, only 43% were knowledgeable about FP. Health extension workers played the leading role (75%) in information dissemination of FP methods. Among public health facilities, 79%, 54% and 17% of mothers stated health centers, health posts, and private clinics, respectively, as places where they can get FP methods. Implant was relatively highly preferred method as compared to other methods.

Table 1: Socio-demographic characteristics of women in the study zones.

Variables		Number	Percent
Residence	Urban	432	32.0
	Rural	917	68.0
Age	15 – 24	299	22.2
	25 – 34	709	52.6
	35 – 49	341	25.3
Level of Education	No schooling /unable to read & write	687	50.8
	No schooling but read and write	22	1.6
	Primary, Secondary and Preparatory School	609	44.9
	Diploma and above	34	2.5
Partner's Educational level	No schooling /unable to read & write	343	25.4
	No schooling but read and write	64	4.7
	Primary, Secondary or Preparatory School	848	62.7
	Diploma and above	82	6.1
Religion	Others	15	1.1
	Orthodox	406	30.1
	Muslim	343	25.4
	Catholic	2	0.1
	Protestant	563	41.7
Occupation	Other (Hawariat, Wakefeta,)	37	2.7
	Farmer	454	33.5
	Business man (merchant)	197	14.5
	Government employee	39	2.9
	Private employee	20	1.5
	House wife	614	45.3
	Daily laborer	25	1.8
	Others (Student, ...)	3	0.2
Ethnicity	Oromo	1230	91.0
	Amhara	86	6.4
	Tigre	5	0.4
	Gurage	19	1.4
	Others (Yem, ..)	12	0.9

Seventy-one percent of women reported ever use of FP methods, of whom 76% were protestants, 75% Orthodox, and 61% Muslim. Out of them, 36% used it for

limiting and 64% for spacing children. The current use of modern-contraceptives was 59%. Injectables were the most commonly ever and currently used modern contraceptive method (62.7% and 66.2%) followed by implants (5.1% and 18.8%) and pills (31.3% and 8.5%) (Figure 1). Decision to seek contraceptive was made jointly for majority (58%) of the women, while one-fifth of the women were the sole decision makers to get the FP method. About 64% recalled as they had been counseled about FP methods and related issues by FP service providers, while only 10% were informed about method effectiveness and only 3% were instructed on how to use the methods.

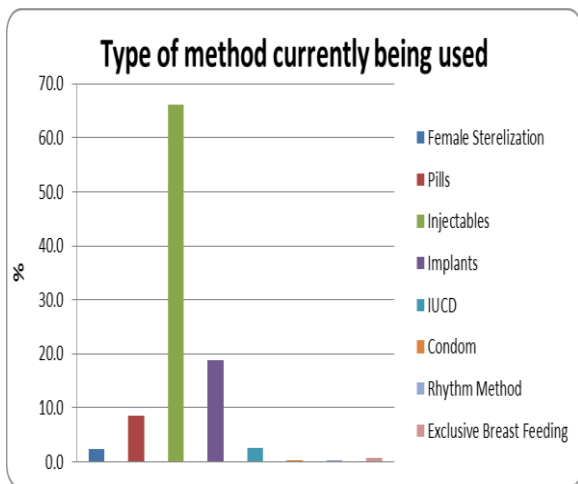


Figure 1 Types of contraceptive methods currently in use by women

About half (52%) of mothers obtained their choice of FP methods from health centers, 31% from health posts through health extension workers, and 3% from government or private hospitals and pharmacies. Only very few complained that the facility where the service was available was located far away or inconvenient to access; the method was expensive to purchase; had difficulty of being served by facility workers; encountered irregular or out-of-stock contraceptive supplies; experienced family or social resistance; there were transportation problems and time constraints. Home-visit coverage during

the last twelve months was low (23%), while health facility visit of mothers in the same period was 49%. Women in the age group 25-34 were 1.58 times more likely to utilize family planning services as compared to women in the age group of 15-24 (AOR = 1.58, 95%CI: 1.12, 2.24) (Table 2).

All mothers had religious pressure not to use modern-contraceptive methods irrespective of their religion type. Those who were Orthodox Christians were 1.65 times more likely to utilize FP methods compared to Muslims or Muslims were 65% less likely to utilize the services compared to Orthodox believers (AOR=0.35, 95%CI: 0.21, 0.60). The other categories of religion (Protestant, Catholic and others) did not show association. Women who had primary, secondary and above education were 2.09 and 1.52 times more likely to utilize family planning services compared to those who did not have the same level of education (AOR 2.09, 95% CI: 1.11, 3.92; 1.52, 95%CI: 0.64, 3.46). There was also association between FP utilization and community in different districts.

A woman whose partner/husband is merchant was 2.07 times more likely to utilize FP services (AOR =2.07, 95%CI: 1.33, 3.25) compared to woman whose partner's/husband's occupation was farmer. Likewise a woman whose partner/husband was either government employee, private employee or daily laborer was 2.34 times (AOR = 2.34, 95%CI: 1.59, 3.46) more likely to utilize family planning services compared to woman whose partner's/husband's occupation was farming (Table 2).

Qualitative Findings

According to most mother discussants, community awareness has been established to the level that everyone was able to protect unwanted pregnancy, mainly through health education sessions while they visited health centers. Most discussants had the savoir-faire on the

advantages of taking contraceptives for saving wealth, growth of children, mother and children's health, and overall well-being of families. Supporting this argument, a respondent woman stated, "If we didn't take contraception properly we might give birth now and then without

reasonable spacing. As a result we might not be in a position to breastfeed our child for at least two years and if that is not the case the child may not have good resistance to many diseases. Lack of breastfeeding also affects mental growth of the child."

Table 2: Logistic regression analyses of the relative effect of socio-demographic, and knowledge variables on FP method.

Explanatory Variables	FP Utilization		Crude OR(95%CI)	Adjusted OR (95%CI)	p-value
	Yes (n)	No (n)			
Age (years)					
15-24	210	84	1		
25-34	522	174	1.20 (.88, 1.63)	1.58(1.12, 2.24)	0.01
35-49	212	119	0.71 (0.51, 0.99)	1.14(0.77, 1.67)	0.5
Religion					
Orthodox	295	101	1		
Muslim	205	129	0.54(0.40, 0.75)***	0.35(0.21, 0.60)	0.000
Protestant + Catholic	444	149	1.02(0.76, 1.37)	0.95(0.66, 1.35)	0.76
Educational Background					
No School	794	358	1		
Primary School	103	14	3.31(1.87, 5.88)***	2.09(1.11, 3.92)	0.02
Secondary School	48	7	3.09(1.39, 6.90)**	1.52(0.64, 3.61)	0.35
Partner's Occupation					
Farmer	549	298	1		
Merchant	138	33	2.27(1.51, 3.40)***	2.07(1.33, 3.25)	0.001
Employed (Government, Private, Daily laborer and others)	258	47	2.98(2.12, 4.19)***	2.34(1.59, 3.46)	0.000
Zone					
East Wollega	124	90	1		
Illubabor	150	34	3.20(2.02, 5.08)***	6.11(3.27, 11.42)	0.02
Jimma	101	80	0.92(0.61, 1.37)	2.06(1.17, 3.67)	0.01
West Showa	262	124	1.53(1.09, 2.17)*	1.38(0.93, 2.03)	0.11
West Wollega	308	51	4.38(2.93, 6.55)***	4.92(3.22, 7.53)	0.000

*** Significant at p-value <0.001, **at p-value <0.01, *at p-value <0.05

It is observed that there was no a problem of availability of the contraceptive methods in the zones. However, sometime ago there was a scarcity of DIPO and pills. One service provider stated, "For a short period of time DIPO was not available not only in our health center but also at the Woreda level." Acutely, there was also a shortage of lido cane, glove, etc. We have been supplied by different organizations. IPAS (which played a major role in solving that acute shortage) gave us LAFP methods, including their consumables like alcohol, glove, and cotton."

As has been ascertained by the key informants that most of the women preferred to use short-term methods, specifically DIPO, for the fact that it is believed to be relatively convenient for them as compared to other long-acting

methods. Even those who had maximum number of children (eight or more) preferred DIPO for that specified reason. There were guidelines and procedures to deliver family planning services to women which recommend counseling the client about FP procedures at first, followed by proper provision of the services. There were challenges against these in some facilities. Concerning counseling one discussant service provider said: "After we counsel, they tend to use their previous choice. One of my clients asked me whether I had DIPO to give her or not at the moment. If I fail to do so, she will go back to home & doesn't want to use anything other than that. She didn't receive what we recommended."

There was also limitation on the skill of service provision. One respondent said, "My sister wants to use implants and

goes to health center. During the insertion there was excessive bleeding and she suffered a lot. Within a very short period she went to hospital for removal before the end of prevention period. Now, she is using DIPO instead of implants”.

Implanon and IUCD were not being highly utilized by the community. Major reasons mentioned were religious pressure, lack of skill of service delivery; unwillingness of husband/partners, feeling shameful to have the IUCD inserted in the uterus and fear of side effects. For Muslim women in both rural and urban settings religious pressure was the commonest reason. Supporting this argument one health provider said, *“The main challenge our clients raised on LAFP is related to religion. Muslims believe that if a mother happens to pass away with Implanon inserted, her soul would not get into haven. We showed them all the methods available but they have no tolerance even to finish the counseling session. When they hear the name “implanon” they appear outraged”.*

The other reason for the low level utilization of Implanon and IUCD was lack of skilled and trained health professionals to provide the services. As witnessed by a service provider in one of the health facilities, after counseling a mother to use IUCD for family planning, no one was around to provide the method.

There were also misconceptions and beliefs in the community LAFP. A misconception which was assumed to be the main reason for not using modern contraceptives was fear of side effects. Some of the side effects do not exist in the real sense and some are too exaggerated. The common side effects mentioned by the respondents were that women using Implants need additional food than they are usually take under normal circumstances; are exposed to psychosis, a decrease body blood levels, headaches, getting painful arms, and the like. They believed contraceptives inserted in uterus

cause infertility, and the ones implanted in the arms lead to faintness. On the other hand, there was a group in the community which perceived FP methods were being used in order to limit the size of their ethnic population.

Health extension workers, most of the time, were capable of providing FP methods which do not require complicated clinical procedures like condoms, Pills and DIPO and usually refer to the health center those who want to use LAFP methods. According to one discussant, trained HEWs were trying to provide Implanon. However there was shortage of supply and they were forced to refer women demanding LAFP methods to the nearby hospitals.

Government and non-governmental organizations like Engender Health and Marie Stops International provide insertion training in Implanon and IUCD in some Woredas for health extension workers, midwives and nurses. Comprehensive FP training was also given. Menschen für Menschen provides training for health professionals for the purpose of outreach services. Those who had gotten comprehensive need refresher training and those who took basic training were also in need of complete FP training, including in Implanon & IUCD insertion & removal.

There were zonal reports/data compiled for FP service for the past five years. However, there was no formal trend analysis conducted to identify factors affecting RH/FP services utilization and to indicate quality of counseling and methods mix.

In the previous days, there was an old curriculum used to train regular midwife students for three years. Currently, the college is conducting “accelerated midwifery training” for those primarily trained in nursing for one year. There is a difference between the two curricula in terms of their RH/FP contents. According to the discussants, unlike the previous curriculum, RH/FP topics are

fascinatingly included as a course in the new curriculum. The curriculum is designed satisfactorily, and does not have any defect if implemented effectively. In the colleges, recording books, tally sheets, and Implanon were available. However, FP training materials were not sufficient. For example, materials required for demonstration session, like models for practicing IUCD insertion and removal were limited. One of the Health Science College deans said, *“We are taking some materials from the nearby hospital and there is a time when we cannot find any logistics and students complained about the situation and sometimes we use videos instead of demonstration”*. The majority of the discussants mentioned that theoretical sessions have been conducted successfully. However, they hesitated to confirm graduates acquired basic knowledge and skill that can enable them to provide the services as expected. This is because the graduates were not given the opportunity to practice on IUCD models and classroom sessions were not supported by model demonstrations. They also reported that there was less familiarization of equipment; tutors were not trained in RH/FP; shortage of resources for FP/RH training in school, inconvenient classroom settings (narrow demonstration rooms); insufficient caseloads at health facilities (mainly LAFP) and unmanageable number of students assigned for practical sessions.

From the discussion it was deduced that pre-services training in RH/FP mainly on LAFP would be very important. Because pre-services training may be specific and focused, the majority of the discussants recommended LAFP methods and specifically Implanon and IUCD to be included in the pre-service training.

According to most discussants, there is skill gap among instructors on LAFP. Supporting this argument an instructor said, *“I have taken FP as only one sub-topic of BEMOC training. I am teaching midwifery based on the*

knowledge and skill I have gotten from that training. I do not know any instructor who was trained in LAFP. Therefore, we need training to skillfully deliver the pre-service training”. There was high turnover of staff. Those who get experienced would leave the institutions frequently.

DISCUSSION

Overall, most married women in the age of 15-49 had information about FP methods, which indicates that the government's FP education interventions are succeeding in raising FP awareness. However, the information was superficial as their knowledge about FP methods was limited and not consistently translated into behavioral change that leads them to utilizing FP services as much. This marks that knowledge, but not awareness, is a main barrier to utilization of FP services. It also indicates that Universal FP information in the community, in the absence of adequate FP knowledge, doesn't guarantee effective utilization of FP services. This finding concurs with related studies held in Ethiopia. ^[6,7]

Although religion has a major influence on a variety of social attitudes, the relationship between religion and views on FP remains largely unexplored. ^[8] Our findings indicate that religion, irrespective of its type, remains a major barrier to utilization of FP services.

According to the national FP service strategies, FP services intend to be delivered through community-based services, facility-based services, social marketing, and outreach services. Our study shows that mothers are accessing structured FP programs that provide modern-contraceptives and related services at health facility levels. However, community-based FP services were weak due to limited home-based FP counseling and services which require regular house-to-house visits to each mother. Findings of this study confirmed that only 23% of mothers received house-to-house FP visits

by health extension workers in the last one year. A similar result (20%) was reported in another study conducted in Ethiopia based on analysis of the 2000, 2005, and 2011 Demographic and Health Surveys. [9]

Equally, a wide range of investments are needed to improve FP counseling and service delivery skills of the health workforce. Findings from key informants and discussants reassured that health professionals, specifically health extension workers, have limitations in counseling and providing FP services. Thus, implementing partners which are working closely with national and regional health bureaus should continue building technical competency of health professionals to enable them to effectively provide FP services, particularly the LAFP. Besides, special attention should be paid to FP in the job description of health extension workers. Existence of detailed description of FP activities would lead health care providers to focus on major FP interventions and ensured quality of FP services. [10]

Overall FP prevalence in the study (59%) was higher than the national prevalence of 42% [2] and the of South Central Ethiopia prevalence of 25.5%, [4] but lower than the 64% reported in Benishangul Gumuz Regional State, west Ethiopia. [6] If all stakeholders could scale up the efforts to sustain the expansion and utilization of the services, Ethiopia, and particularly the Oromia region, will be able to achieve the FP 2020 target. On the other hand, more than two-thirds of the respondents need to have four or more children in their family which is twice the replacement fertility level of the population. Therefore, it is high time to work on the community to bring behavioral and attitudinal change to achieve the FP 2020 target.

Looking at the proportion of women who ever used FP methods, much remains to be done to maximize utilization of LAFP. For instance, even though high

number (84%) of mothers has heard of implants, paradoxically 82% of them have never used these methods. Duration time of contraception, availability/supply, ease of use, affordability, reliability and as a result switch from pills to implants might be the possible reasons among others. A great majority of respondents from Jimma zone of the Oromia regional state have never used implants and one-thirds of the respondents also have discontinued using these methods. Even though discontinuing using a method is an area that seeks the attention of health professionals to work on, end of prevention method is the main reason for them to stop using implants; this makes the overall implant utilization encouraging. Compared to implants, more respondents have discontinued using IUCD and partner/husband opposition and fear of side effects/complications are considered to be the reasons. It is also worth mentioning here that 14% of the respondents had faced abortion while Ethiopia had been highly working to improve maternal health to achieve Millennium Development Goal 5.

CONCLUSION

In general, though the Ethiopian government has continued to improve awareness of and access to FP services, utilization remained less, mainly due to limited FP knowledge in the community, low home-based FP coverage, and religious influences. Thus, meeting the FP2020 targets requires a high level policy and political environment that would create skilled and well-motivated health workforces who can provide essential FP knowledge and services to the community. Universal FP information made available to communities, in the absence of adequate FP knowledge, doesn't guarantee effective utilization of FP services. Similarly, home-based FP coverage is highly important in communities that are not utilizing FP services accessible at health facilities. Besides, in countries such as Ethiopia with

fervent religiosity, knowledge about natural-contraceptive methods is important to help religious people make an informed decision about FP in accordance with their faith.

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