

*Addis Ababa University Graduate Studies*



**Demand for long acting and permanent  
contraceptive methods and associated factors  
among family planning service users, East Shoa  
Zone, Batu town, Ethiopia.**

**By**

**Anley Haile**

**Thesis submitted to the School of Graduate Studies of  
Addis Ababa University, Faculty of Medicine, and School  
of Public Health, as a partial fulfillment of the  
requirements for the degree of Master of Public Health.**

**Jun 2009**

**Addis Ababa, Ethiopia**

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# Acronyms

<b>CBRH</b>	Community based reproductive health
<b>CBRHA</b>	Community based reproductive health Agents
<b>CPR</b>	Contraceptive Prevalence Rate
<b>DHS</b>	Demographic and health survey
<b>FGAE</b>	Family guidance association Ethiopia
<b>FP</b>	Family panning
<b>HIV</b>	Human immune deficiency virus
<b>IEC</b>	Information education communication
<b>IUD</b>	Intrauterine devices
<b>LAPM</b>	Long-acting and permanent contraceptive methods
<b>MOH</b>	Ministry of health
<b>NGOs</b>	None governmental organizations
<b>QIQ</b>	Quick Investigation of Quality
<b>SDPs</b>	Service delivery points
<b>TFR</b>	Total fertility rate
<b>TWFR</b>	Total wanted fertility rate

# Abstract

**Introduction:** Evidence suggests a substantial unsatisfied demand for LAPMs in sub-Saharan Africa. A discrepancy exists between the proportion of women who wish to stop having children (unsatisfied demand) and the proportion who are using LAPM (satisfied demand); however, there is limited evidence to show demand for LAPMs and associated factors in Ethiopia.

**Objective:** The objective of this study was to assess demand for long acting and permanent contraceptive methods and associated factors among women of age group 18-49 years in Batu town, East shoa Zone, Ethiopia.

**Methodology:** A facility based cross sectional survey was conducted in six service delivery points from March to April 2009 on 398 women of age 18-49 in East Shoa zone Batu town. Quick Investigation of Quality (QIQ) approach with a little modification was used. By using well-structured questionnaire and comprehensive checklists client exit interview, observation of client provider interaction and facility audit were carried out.

**Results:** Among 398 women of the study participant only 13(3%) were currently using LAMPs and 89(22.4%) wants no more child in the future, this makes the total demand to be 24.4%. Some factors in this study were significantly associated with demand for LAMPs like: Age, number of children (parity), the provider ask about reproductive intention, and the provider explained side effects of method selected (p-value <0.05).

**Conclusion and Recommendation:** The findings of this study demonstrated that there was a big gap between the satisfied and unsatisfied demand and also the total demand was higher. In addition to that there were several aspects of socio

demographic and family planning service quality related factors found to be significantly associated with demand for LAPMs. So that multi dimensional measures are needed to improve the quality of family planning services, and efforts are needed to meet the unsatisfied demand.



# 1.Introduction

## 1.1 Background information

As of July 2008, the world's population is estimated to be just over 6.684 billion. In line with population projections, this figure continues to grow at rates that were unprecedented before the 20th century, although the rate of increase has almost halved since its peak of 2.2 percent per year, which was reached in 1963. The world's population, on its current growth trajectory, is expected to reach nearly 9 billion by the year 2042. (1)

Currently, 500 million women in the developing world are using some form of family planning, thereby preventing 187 million unintended pregnancies, 60 million unplanned births, 105 million induced abortions, 2.7 million infant deaths, 215,000 maternal deaths and 685,000 children from losing their mothers due to pregnancy-related deaths each year. However, another 200 million women throughout the developing world who would like to delay or limit their births lack access to contraceptives. Providing these women with the services they need would prevent an additional 52 million unintended pregnancies and 23 million unplanned births each year. (2)

In the past 40 years, family-planning programmes have played a major part in raising the prevalence of contraceptive practice from less than 10% to 60% and reducing fertility in developing countries from six to about three births per woman. However, in half of the 75 larger low-income and lower-middle income countries (mainly in Africa), contraceptive practice remains low and fertility, population growth, and unmet need for family planning are high. The crosscutting contribution to the achievement of the Millennium Development Goals makes greater investment in family planning in these countries compelling. (3)

Between 1990 and 2000, total fertility in Ethiopia declined from 6.4 to 5.9 births per woman. This is a significant achievement by any standard, but the current rate still remains high. In rural areas, women bear an average of 6.4 children – nearly double that of their urban counterparts (4) Population growth, meanwhile, remains around 2.7 percent annually, making Ethiopia Africa's second most populous country with an estimated population of 77.4 million in 2005 (5).

A strong population and social development policy is enormously important in providing the underpinnings and preparing the public for family planning (6). Accordingly the Ethiopian national reproductive health strategy set some crucial strategies for family planning. These are: create acceptance and demand for FP, with special emphasis on populations rendered vulnerable by geographic dispersion, gender, and wealth; increase access and utilization of quality FP services, particularly for married and unmarried young people and those who have reached desired family size; delegate to the lowest service delivery level possible, the provision of all FP methods, especially long-term and permanent methods, without compromising safety or quality of care (7).

The contraceptive prevalence rate for married Ethiopian women is 15%. Almost all of these users are using modern methods. The most widely used method is injectables (10%) followed by the pill (3%). But the prevalence of long acting and permanent method is very low and it accounts; female sterilization 0.2%, intrauterine devices IUD 0.4%, Implants 2.0% among all women. (8)

Women and couples who want safe and effective protection against pregnancy would benefit from access to more contraceptive choices, including long-acting and permanent methods (LAPMs) these are: IUDs, implants, female sterilization, and vasectomy. LAPMs are convenient for users and effectively prevent pregnancy. They are also cost effective for programs over time, can result in substantial cost savings for governments, and contribute directly to reaching national and international health goals. Despite these advantages, LAPMs remain a relatively small, and sometimes missing, component of many national reproductive health and family planning programs. (9)

## 1.2 Statement of the problem

Population growth is a major concern in developing countries in view of its impact on broader socio-economic development. In Sub-Saharan Africa, including Ethiopia continued high fertility levels, along with declining mortality rates, have resulted in a wide gap between birth and death rates, and subsequently in high annual population growth rate. Factors contributing to high fertility include low socio-economic development, deeply ingrained cultural values for large family size, and low levels of contraception.

A study done on family planning in Tigray, Amhara, Oromia, and SNNPR regions shows that the average Total Fertility Rate was 5.6 children per woman with little significant difference between regions. Urban fertility is 26% lower than rural fertility for all the four regions combined. Most women give birth while they are in their teens, as a consequence of the early age of marriage. Among women currently pregnant, a significant proportion (about 40% in Tigray, a little over 40% in Amhara, 31% in Oromia and 37% in SNNPR) reported that the pregnancy was unwanted or mistimed suggesting that these pregnancies could have been prevented if women had had access to family planning services. (10)

In 2005, about 49% of Ethiopian women reported that they wanted no more children or they want to wait for at least two years to have their next child. , Yet, only about 15 % were using contraception, which reflects an unmet need for contraceptives of about 34%. In 2000, demand for contraception was 40%, and it increased sharply, by about 25% between 2000-2005. Because demand grew faster than use, unmet need for contraception continues to be high. Although the TFR was 5.4 in 2005, total wanted fertility rate (TWFR) was only 4 children per woman meaning that there is about 1.5 unwanted births per woman. (11)

Knowledge of contraception has remained high in Ethiopia over the past five years. For example, knowledge of any modern method among currently married women was 85 percent in 2000 and 87 percent in 2005. But selectively knowledge on long term and permanent contraceptive methods is very much lower and female sterilization 18.4%, male sterilization 6.6%, IUD 14.85, and implants 22.4% among all women.

(8)

Although short-acting methods provide contraceptive coverage for many women who do not want more children, these women are still entitled to a choice of contraceptive methods. LAPM may be a good option for some of them, given their reproductive intentions, but they may not be using one because of lack of knowledge or access. Women who are not satisfied with short-acting methods but still wish to avoid pregnancy need alternative family planning choices. In developing countries, 20% to 30% of women who use oral contraceptives or injectables stop within two years of starting because of side effects or other health concerns. Many of these women could benefit from switching to LAPMs. (9)

### **1.3 Rationale of the Study**

Contraceptive use has increased worldwide over the last decade. Yet, Africa—like many other regions of the developing world—continues to have a high unmet need for family planning. Approximately 25 percent of women and couples in sub-Saharan Africa who want to space or limit their births are not using any form of contraception. More than half of the people in Africa are younger than 25 years old, so unmet need is only expected to increase as these individuals enter their reproductive years. Over time, the use of LAPMs has not kept pace with that of short-acting methods, such as oral contraceptives and injectables. Data from demographic and health surveys from four sub-Saharan countries show that the proportion of women currently using LAPMs is significantly lower than the proportion using short-acting methods. In many countries in the region, including Ethiopia, fewer than 5 percent of women who are using contraception are using LAPM. Thus there is a need to assess demand for LAPMs and associated factors in diverse developing country setting including Ethiopia.

## 2. Literature review

### 2.1 Use of LAPMs

The 2002 Maternal and Child Health Survey in Guatemala showed that 43% of married women in fertile age use a contraceptive method, 34% of which use a modern method. Among these users, the most popular methods are female sterilization (17.8%), injectables (9.0%), oral contraceptives (3.4%), and condoms (2.3%). Only 1.9% of women living in union use IUDs, a smaller figure than that recorded in 1999 (2.2%) and in 1995 (2.8%). More women in urban areas (3.4%) use IUDs compared to women in rural areas (0.9%); more *non-indigenous* use IUDs (2.4%) than indigenous women (0.4%). Therefore, a population group that has greater access to services and a comparatively higher socioeconomic level uses the IUD. (12)

In Ethiopia in areas where strong donor supported family planning programs were carried out through CBRH programs, use of LAPMs is much higher than the national one. (8)

A study done on prevalence and factors affecting use of LAPMs in 2008, in Jinka, SNNPR, Ethiopia showed the prevalence of contraceptive among participants was about 39.5%. Of this LAPMs contributes for 7.3%. Implant is the most widely used method from LAPMs contributing to almost half (50%) of the LAPMs users. There was very low (18%) knowledge of LAPMs in Jinka town. Among LAPMs, Implant is known by most (76.1%), and the least known is male sterilization (17.4%). A considerable proportion, (63.5%) of participants had intentions to use LAPMs in the future. (13)

## **2.2 Factors associated with demand for LAPMs**

### **2.2.1 Service quality**

One of the major factors associated with demand for LAPMs is quality of family planning service. Improved quality of care is an increasingly important goal of international family planning programs, for a variety of compelling reasons. From a human welfare perspective, all clients, no matter how poor, deserve courteous treatment, correct information, safe medical conditions and reliable products. It also has been argued that providing such quality services will lead to increased service utilization by more committed users, eventually resulting in higher contraceptive prevalence and lower fertility. (14) A study done on family planning services quality as a determinant of use of IUD in Egypt showed that the unadjusted relative risk ratios the quality of family planning services had a significant positive effect on the use of IUDs from public sources (RRR = 1.23;  $p < 0.05$ ). (24)

### **2.2.2 Perceived Cost**

LAPMs are cost-effective for programs over time. When compared with the use of other methods, use of LAPMs results in fewer unintended pregnancies and fewer clinic visits. This eases the burden on already overextended health systems and providers. If used for at least three years, the IUD, vasectomy, and implants are considered the three most cost-effective methods when all direct medical costs associated with the methods, side effects, and unintended pregnancies are taken into account, but most clients consider the first time cost of methods which is technically greater than any other methods. In this regard client may not tend to realize the over all cost, so that they will not use those methods. (15)

### **2.2.3 Educational status**

Women with secondary or higher education and urban women show higher demand for and use of contraception than their less educated or rural counterparts, and they are nearing the replacement-level of fertility (TFR of 2.2-2.4). Women in Addis Ababa have a TFR of 1.4, markedly below replacement-level fertility and more in common with Italy or Singapore. Only 10 percent of women with no education use contraception, though it is used by 53 percent of women with secondary education.

Unmet contraceptive need is 35 percent for women without education, while only 17 percent of women with secondary or higher education have unmet need. (11) In addition, the study done in Guatemala showed that more women with high school or higher education (5.2%) use IUDs than women with elementary education (1.4%) or without formal schooling (0.4%). (12)

### **2.2.4 Myths and misconceptions**

**A study done on LAPMs in Uganda showed that poor knowledge about the effect of the use of long-term methods on fertility as well as poor understanding of the procedures, particularly for vasectomy, have led to the fuelling of myths and beliefs that hinder the successful promotion and adoption of the services. Myths and beliefs like: - Vasectomy involves removal of the testicles and that it thus renders a man unable to achieve an erection, man who has undergone vasectomy would also be unable to**



## Demand for LAPMs

### Other factors

- Knowledge on LAMPs
- Myths and Misconceptions
- Partner influence

**Fig.1: -A conceptual framework: - Demand for long acting and permanent contraceptive methods, East Shoa zone, Batu town, May 2009.**

As shown in figure-1 several factors affect demand for LAPMs. Some of the factors are socio demographic, others include policy and supply factors, service quality related and some others are related to: - knowledge, myths and misconceptions and partner influence. In this study socio demographic, quality related, knowledge, myths and misconceptions and partner influence were considered

## 3.Objectives

### 3.1 General Objective

- To assess demand for long acting and permanent contraceptive methods and associated factors among women of age group 18-49 years in Batu town, East shoa Zone, Ethiopia.

### 3.2 Specific objectives

- To assess satisfied, unsatisfied and total demand for long acting and permanent contraceptive methods.

- To identify the predictor factors of demand for long acting and permanent contraceptive methods.

## 4. Methods

### 4.1 Study Design and Area

**This facility based cross sectional survey was conducted in East Shoa Zone of the Oromiya Regional State. East Shoa Zone is located at the center of the country with boundaries with the capital Addis Ababa, Afar Regional State and other adjacent zones in Oromiya Region. The capital of the zone is Adama town and it is 100 Kms from Addis Ababa. There are a total of 12 woredas under the zone. There are also three towns, including**

the capital Adama that are known as special zones and directly administered by the regional council. The total population of the zone is estimated at 2.3 million out of which 1.8 million are inhabitants of east Shoa zone without including the three special zones. According to the East Shoa zone health desk there are 5 hospitals (one owned by for-profit, two owned by government sugar factories), 14 health centers, 78 private for-profit clinics, 44 government owned clinics (10 by government sugar factories) and 110 health posts. There are only 6 medical doctors, 11 health officers and 172 nurses working in the zone. However, number of health professionals may be underestimated because of the poor private – public collaboration in reporting.

## **4.2 Study population**

The source population was all women of age from 18-49 years, who were using family planning service in different service delivery points and all providers of family planning service.

### **Inclusion criteria**

*a) Health professionals:*

- Stay more than 3months on the same SDP.

*b) Clients:*

- All F/P clients age from 18-49 years

**Exclusion criteria**

***a) Health professionals:***

- **Staff not involved in direct care of F/P clients**
- **Refusal to participate**

***b) Clients:***

- **Non F/P clients**
- **Age less than 18 years and above 49 years**
- **Refusal to participate**

### **4.3 Sampling Methods and Procedures**

#### **Health institutions**

**There are a total of 12 woredas and three towns, including the capital Adama that are known as special zones under east Showa zone. Among towns and woredas, which have at least 8-health institutions and give family planning services, Batu town was selected purposively. Besides**

having more than eight health institutions, peoples who are using health services in Batu town came from both urban and rural areas.

In Batu town there are one private hospital, one health center, one NGO clinic, nine medium clinics. Among them six health institutions was selected from different levels including hospitals, health centers and clinics with different ownership like: governmental, private and NGOs. The private hospital, the health center, and the NGO clinic was selected as there was just one of each; and lottery method was applied to select three medium clinic from nine.

### **Clients**

All clients who came for family planning within the study period was interviewed and the number of clients for each health institution were determined by the current flow of clients. The interview was made at exits.

#### **4.4 Sample size**

## Sample size for clients

The required sample size for clients exit interview was determined by using the following assumptions to estimate sample size of single population proportion.

$$n_o = \frac{(Z_{\alpha/2})^2 P(1-P)}{d^2}$$

**Assumptions:**

**Desired precision (d)** = 5%

**Expected prevalence (p)** Demand for long acting and permanent contraceptive methods in Ethiopia is 47 %. (Source ORC Macro. MEASURE DHS STAT compiler)

**Confidence level** = 95%, which means  $\alpha$  set at 0.05 and  $Z_{\alpha/2} = 1.96$  (value of Z at  $\alpha$  0.05 or critical value for normal distribution at 95% C.I.).

Hence, the calculated sample size was 383. Adding a 10 % non-response rate gave the required minimum sample size (n) 421.

## 4.5 Data collection

### 4.5.1 Data collection instruments

Judith Bruce's well-known quality-of-care framework provides an excellent starting point for the development of evaluation tools and indicators based on the six central elements of quality. Based on this framework, a number of useful methodologies have been developed to evaluate some or all of the six elements, among them we have chosen the Quick Investigation of Quality (QIQ) approach with a little modification to include other determinants which could affect demand for LAPMs so as to evaluate how quality and other factors affect demand for long acting and permanent contraceptive methods.

Data were collected by using well-structured questionnaire and comprehensive checklists for facility audit and for observation of client provider interaction.

**Variables**

***Dependent variable***

Demand for LAPMs

***Independent variable***

**Client characteristics:** Socio- demographic characteristic such as: Age, occupation, marital status, educational level and religion; parity, reason for visit, knowledge about LAPMs, myths and misconceptions, partner influence, choice of method, desire for another child, spacing, satisfaction with information given, waiting time, clinical procedure, method accepted, cost of method.

**Provider characteristics:** sex, qualification, training, and supervision, counseling skill and skill during clinical procedure.

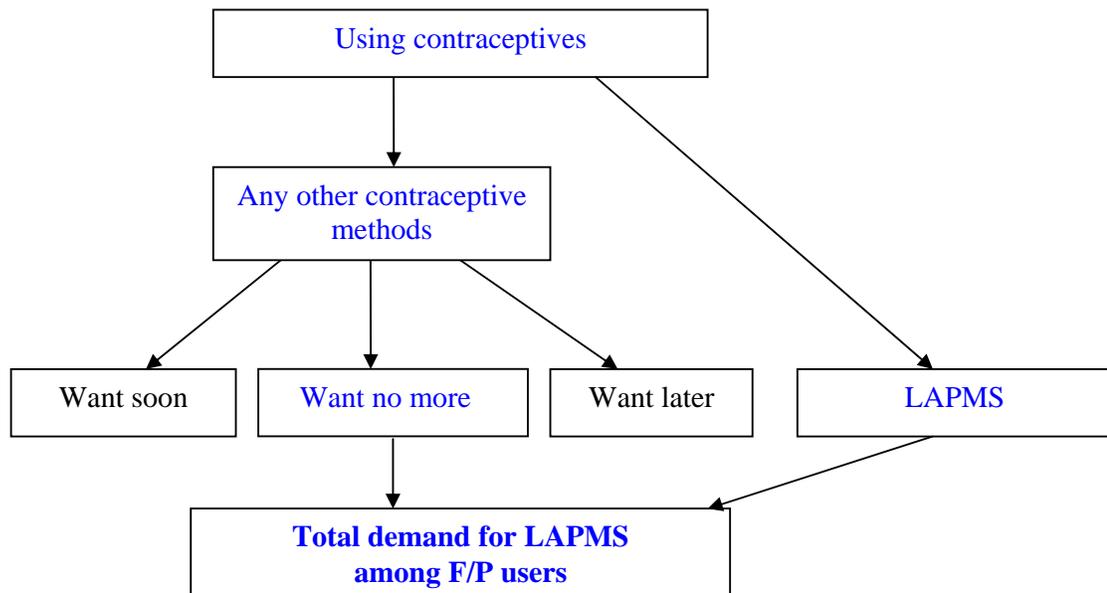
**Facility characteristics:** Supplies, equipments, IEC materials, service hours, method availability, and infrastructure.

***Operational definitions***

**Family Planning Providers:-**A health professional who is assigned in family planning service area and responsible to provide family planning methods and counseling service on family planning methods and related conditions.

**LAPMs-** Four contraceptive methods are categorized as long acting or permanent (LAP/P): intrauterine devices (IUDs), implants, female sterilization, and vasectomy. IUDs and implants are long-acting temporary methods; when removed, return to fertility is prompt.

**Demand for LAPMs** will be determined by adding the percentage of women who are using a long-acting or permanent method and the percentage of women who are using any other method and report wanting no more children.



**Fig.2: - Illustration of calculation of demand for long acting and permanent contraceptive methods (LAPMs) among F/P users, East Shoa zone, Batu town, May 2009**(adapted from ORC Macro. *MEASURE DHS STATcompiler*. Available: <http://www.measuredhs.com>.)

#### **4.5.2 Data Collectors**

The data collectors for exit interview were female, 12<sup>th</sup> grade complete, those have previous exposure in data collection. Health professionals (Nurses) from Awassa filled the checklists. The facility audit and managerial survey checklist was filled by the principal investigator through direct observation of institutional capacity for family planning services.

#### **4.6 Quality control**

Questionnaire was translated from English to Amharic and Oromiffa and back to English as well to reconfirm consistency and pre-tested on other area one week before the scheduled data collection day. Data collectors were trained to be familiar with the objective and the methodology of the research and to standardize their interviewing technique and to ask question in consistent manner. The principal investigator was closely supervising the performance of the data collectors in the field on a daily basis.

#### **4.7 Data Processing and Analysis**

EPI3.1 and SPSS15.0 were used for data entry, editing and analysis. Frequencies and percentage of different variables was computed for description as appropriate. Odds ratio with 95% confidence interval was computed to asses the presence and degree of association between the dependent and independent variables, multiple logistic regression was used for better prediction of determinants and to reduce bias due to confounders.

#### **4.7 Ethical Considerations**

The data collection was carried out after getting approval for the project proposal from the IRB (Ethical review board) of medical faculty of AAU. Official permission was collected from East Shoa zone health department, and verbal consent was obtained from individual participants. All the participants in the questionnaire survey

were told about their participation would be on voluntary basis and their information kept confident. Moreover, the purpose, procedures of the study, advantages and disadvantages were told to participants.

## **4.8 Dissemination of Results**

The finding of the research will be submitted to the School of Public health, East Shoa zone health department, and other responsible bodies. The result will be presented at the School of Public Health and in different seminars, meetings and workshops. Finally, the findings will be published and disseminated through different journals and scientific publications.

# **5. Result**

## **5.1 Socio demographic characteristics of the study subjects**

A total of 398 women of age 18-49 participated in the survey making a response rate of 94.5%. Out of these 289(72.6%) were continuing clients, and 109(27.4%) were new clients.

**Table 1: - Socio demographic characteristics of study subjects, East Shoa zone, Batu town, 2009.**

Socio demographic Characteristics of participants		
	Frequency	Percentage (%)
Age group of participants (n=398)		
18-24	196	49.2
25-29	155	38.9
30-34	25	6.3
35-39	16	4.0
40-44	4	1.0
45-49	2	0.5
Marital Status (398)		
Married	367	92.2
Single	29	7.3
Divorced	2	0.5
Educational Status (398)		
Illiterate	119	29.9
1-6 <sup>th</sup> grade	124	31.2
7-12 <sup>th</sup> grade	125	31.4
+ 12 <sup>th</sup> grade	30	7.5
Occupation (398)		
House wife	189	47.5
Daily laborer	93	23.4
Merchant	40	10.1
Student	30	7.5
Gov. employee	28	7.0
Unemployed	13	3.3
Others	5	1.3
Religion (398)		
Orthodox	182	45.7
Muslim	110	27.6
Protestant	100	25.1
Others	6	1.5
Number of alive children (398)		
0	31	7.8
1-3	300	75.4
4-12	67	16.8

The majority, 351 (88.1%) of participants were in the age group of 18-29 with mean age of 25 years (Ranges from 18-49, SD  $\pm 5.54$  years, median age 25 years); 367(92.2%) were married, followed by singles, 29 (7.3%) and widowed, 2 (0.5%) and 367(92.2%) had one or more child and the mean number of children was 2.2 (range 1-12). Most of, 182 (45.7%) of participants were Orthodox Christians by religion. Furthermore, about half of participants, 189 (47.5%) were housewives and 279 (70.1%) of them have modern education and 119 (29.9%) were illiterate. (See table 1)

## 5.2 General Knowledge, myths and misconceptions

Of the total participants of the survey, only 232(58.3%) had some general knowledge about LAPMs. Among LAPMs the most known method was implants which accounts for 218(94%), followed by IUCD 155(49.6%) and the least known methods were tubal ligation and vasectomy, accounting for 21(9%) and 18(7.8%) of the responses respectively. The majority of women 211(90.9%) could mention at least two LAPMs and only 21(9%) knew three or more methods as shown in table – 2. Regarding the characteristics of women with respect to knowledge of LAPMs, illiterates and 1-6<sup>th</sup> grade had less knowledge, 55(46.2%) and 53(42.7%) respectively, compared to 7-12<sup>th</sup> grade 99(79.2%) and +12<sup>th</sup> grade 25(83.3%). Looking at their occupational status 22(78.6%) who knew LAPMs were government employee followed by 23(76.7%) students and those with least knowledge were unemployed 5(38.1%).

Myths and misconceptions were wide spread in the study area. Among women who had general knowledge about LAPMs, 77(33.2%) heard myths and misconception. Specific myths that were usually encountered were:

### ***Myth and misconception 1: implants and Health***

**Among women who encountered myths and misconceptions 77(100%), 19(24.67%) said that use of Norplant would affect their health negatively. They said Norplant could cause hypertension, mental illness, anemia, weight gain, uterine mass, headache and fever. Some women 4(5.2%) encountered that implants could move around freely in the body once inserted and could be lost at the day of removal.**

*Myth and misconception 2: Norplant and IUD cause infertility*

A high number of women 17(22%) among those who heard myths and misconceptions said that use of implants might lead to permanent sterility and about 12(15.6%) heard IUD could do the same.

*Myth and misconception 3: IUD and health*

Most women 16(20%) were concerned about the health effect of IUD, 9(11.2%) encountered IUD could cause bad smell of the vagina ('mehatsen yashetal'), the others said it could cause discomfort or pain during intercourse, headache and eat the uterus and make it thin. Also they heard that it could disappear in the uterus.

**Table 2: - General knowledge and myths and misconceptions on LAPMs, East Shoa zone Batu town, 2009**

General Knowledge on LAPMs	Frequency	Percentage
Knowledge of any LAPMs (398)		
No	166	41.7
Yes	232	58.3
LAPMs known (232)		
Implant	218	94
IUCD	115	49.6
Tubal ligation	21	9.0
Vasectomy	18	7.8
Know <=2 methods	211	90.9
Know >= three of the methods	21	9.0
Heard myths & beliefs (232)		
No	155	66.8

Yes	77	33.2
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## 5.3 Service Quality

### 5.3.1 Exit interview and observation

#### 5.3.1.1 Counseling, communication skill, interpersonal relation and follow up

Of the total participant of the study, 228(57.3%) and 221(55.5%) clients were asked about their reproductive intention on exit interview and observation respectively. Information about HIV/AIDS was given only for 165(41.5%) and 163 (40.9%) clients on exit interview and observation respectively. Clients who were treated with respect/dignity by the provider accounted for 348(87%) on exit interview and, 376(94.5%) on observation. Clients who feel the information given during their current visit was just about right were 343(86.2%) and clients who were given an instruction about when to return accounted for 389(97.7%), 377(94.7%) on exit interview and observation respectively.

**Table 3: -Counseling, communication skill, interpersonal relation and follow up in six SDPs, East Shoa zone, Batu town, May 2009**

	EXIT	OBS
<b>All clients (398)</b>		
Asks client about reproductive intentions: more children?	228(57.3%)	221(55.5%)
Mentions HIV/AIDS: discussed?	165(41.5%)	163(40.9%)
<b>New clients (excludes condom users)(104, 107)</b>		
Mentions HIV/AIDS: method protection?	59(55.1%)	42(40.4%)
Discusses dual method use	49(45.8%)	36(33.6%)
<b>All clients (398)</b>		
Treats client with dignity/respect	348(87.4%)	376(94.5%)
Tailors key information to the particular needs of the specific client	343(86.2%)	-----
Gives instruction on when to return	389(97.7%)	377(94.7%)

Staff treats client with dignity and respect (327)	318(97.2%)	-----
<b>New clients only (109)</b>		
Gives accurate information on the method accepted		
Explains how to use selected method	97(88.9%)	88(83.0%)
Explains side effects of method selected	52(47.7%)	47(44.3%)
Explains what to do in case of problems	55(50.5%)	-----

EXIT= result from exit interview

OBS= result from observation of client provider interaction

Of all new clients excluding condom users the provider mentioned about method of protections for HIV for about 59(55.1%), 42(40.4%) clients on exit interview and observation, and dual method of protection was discussed only for 49(45%), 36(33.6%) clients as explained on exit interview and observation respectively.

As shown in table 3, among new clients who received a contraceptive method, the provider gave accurate information on how to use selected method for 97(88.9%), 88(83%) on exit interview and observation, explained side effects for 52(47.7%) on exit interview and, 47(44.3%) observation, and explained what to do in case of problems for 55(50.5%) clients.

### **5.3.1.2 Method selection, confidentiality and partner influence**

Among all the study participants, 314(78.9%) clients who were seen on exit interview and, 247(62.1%) on observation believe the provider will keep their information confidential. And 338(84.9%) of clients said that they participated actively in the discussion and method selection. Among new clients the provider discussed only one method for 56(51.4%) clients, two methods for 5(4.9%) clients and three or more methods for 48(44%) clients to determine which method she would prefer. 89(81.7%) of client received their method of preference. As shown in table 4, the reason for client who did not receive their method of preference were 3(20%) because preferred method was contraindicated, 6(40%) because changed mind after listening the provider and 6(40%) because the provider recommended another method

Of all the 367 married clients, 341(92.9%) discussed with their partner about their method preference and among them 21(6.2%) choose what their partner preferred.

**Table 4: - Method selection, confidentiality and partner influence in six SDPs, East Shoa zone, Batu town, May 2009**

Indicator	EXIT	OBS
<i>All clients(398)</i>		
Client believes the provider will keep her information confidential	314(78.9%)	247(62.1)
Client participates actively in discussion and selection of method (is “empowered”)	338(84.9%)	----
<b><i>New clients with a method preference (109)</i></b>		
Provider discusses with client which method she would prefer		
Only one method	56(51.4%)	----
Two methods	5(4.9%)	----
Three and more methods	48(44.0%)	----
Client receives method of choice	89(81.7%)	89(81.7%)
<b><i>Partner influence (who are married = 367)</i></b>		
Discussed with partner about the method of choice	341(92.9%)	----
Partner force me to choose a method what he want	21(6.2%)	----

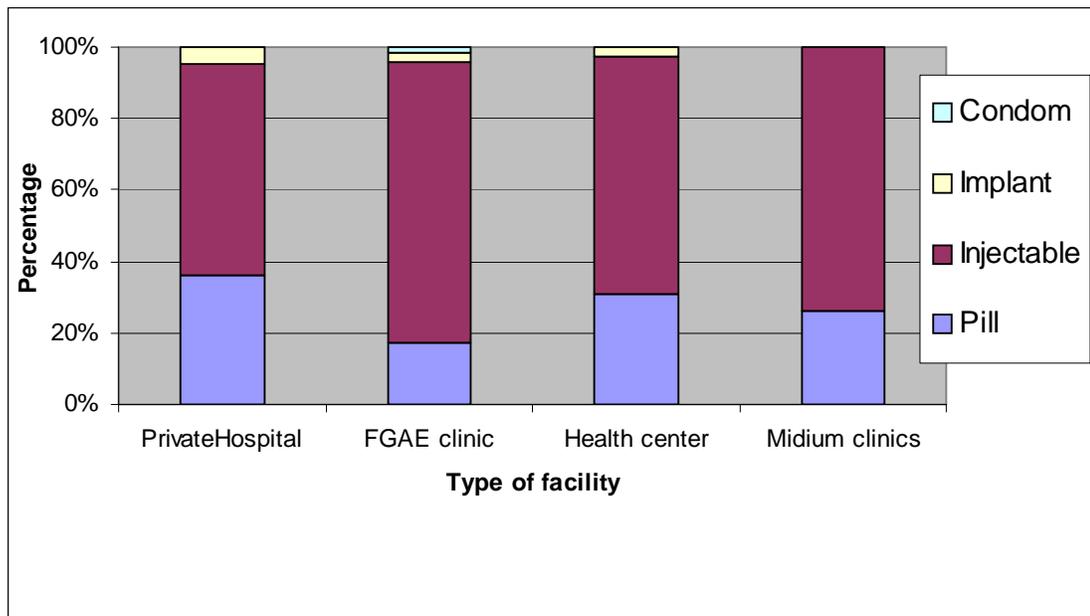
EXIT= result from exit interview

OBS= result from observation of client provider interaction

### **5.3.1.3 Facility readiness and Method mix**

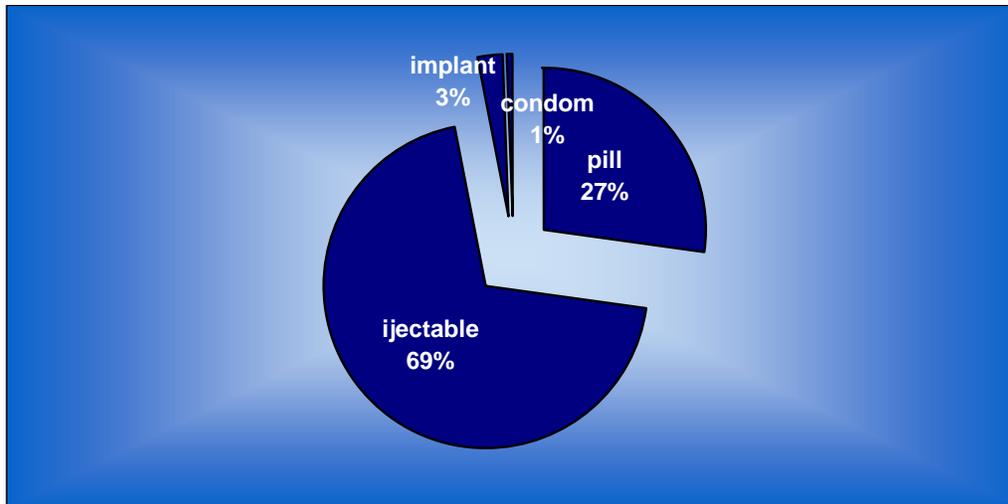
Almost all SDPs opened before 8:00 am and the first client was seen before 8:15 a.m. Except private medium clinics, family planning service was provided only with in working hours. Among all clients in the survey, 392(98.5%) said that waiting time was acceptable and among those who asked about what they feel about waiting time 361(90.7%) said that waiting time was reasonable or minimal.

As shown in figure 1, contraceptive methods received by client at the study period were dominated by injectables. In private hospital implant, pill, and injectables accounted for 5%, 36% and 59% respectively, in FGAE clinic condom, implant, pill and injectables accounted for 2%, 3%, 18% and 77% respectively, in health center implant, pill, and injectables accounts 2%, 31% and 67% respectively, and in private medium clinics only pill and injectables were received by clients and accounted 26% and 74% respectively.



**Fig.3: - Contraceptive method received by clients in different SDPs, East Shoa zone, Batu town, May 2009.**

Of all clients who received contraceptive methods 276(69%) received injectables 107(27%)pill, 10(3%) implants and 2 (1%) condoms.



**Fig.4: - Method mix in six SDPs, East Shoa zone, Batu town, May 2009.**

### **5.3.2 Facility audit**

Among the contraceptive methods, combined oral contraceptives, progesterone only pills, injectables, condom, IUD and implants were available and usually provided in the data collection days in private hospital, FGAE clinic and Health center. In addition to the above methods female sterilization and vasectomy were available but not usually provided in private hospital. Injectable and Contraceptive pill were available and usually provided in three of medium clinics.

Regarding LAPMs all private medium clinics were neither providing nor had those methods with in the last six-month for the different reasons. Reasons mentioned were supplies, equipments and trained staffs were not available. Only implants and IUDs were provided in FGAE clinic and health center. On the other hand all LAPMs were provided in private hospital.

All SDPs had basic disposable items like needles, syringes and gloves, and had examination coach, blood pressure measuring apparatus and clean water supply. All medium clinics had only one IEC material, which was poster, but in other SDPs at

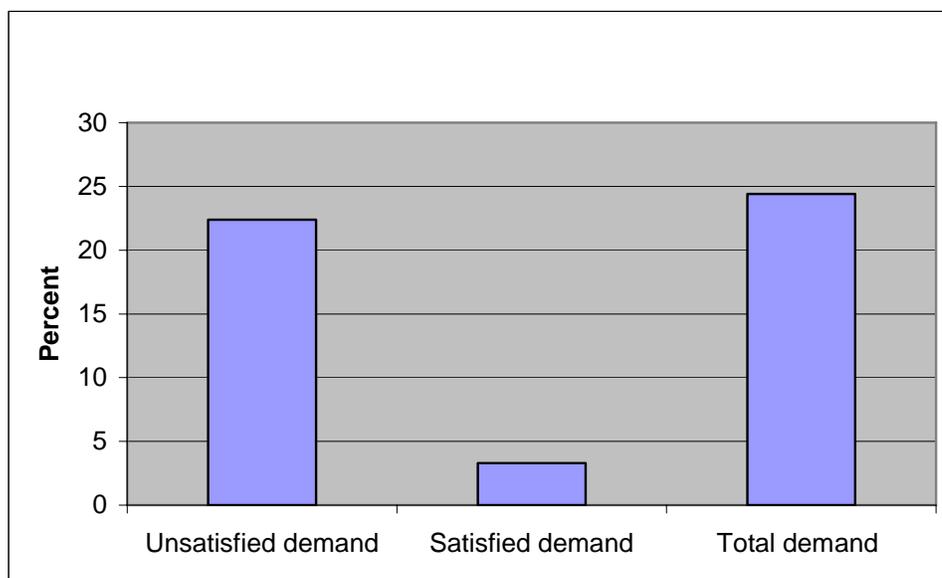
least three types of IEC materials were available. A 1996 MOH written guideline for delivering family planning was available and observed in FGAE clinic, Batu health center and Ruth medium clinic.

Regarding reproductive health focused training, the health center, the FGAE clinic, the private hospital, Bemnet medium clinic had at least one health provider taken training on removal and insertion of IUD and implants with in the last six month. The average duration of training was fourteen days. In the rest medium clinics no one provider was trained on family planning.

All SDPs received a supervisory visit on FP services with in the past 3 months prior to data collection time except one medium clinic. To determine client's opinion on family planning service all health facilities used client suggestion box. Only FGAE clinic and Batu health center were found to have mechanisms to make programmatic change on the basis of client feed back. FGAE clinic had arranged extra room for counseling service and Batu health center had increased the number of family planning service providers to reduce long waiting time.

## **5.4 Demand for LAPMs**

The total demand among clients who were using family planning service was 24.4%, which is a sum of satisfied and unsatisfied demand. Satisfied demand /current LAPMs user in six SDPs were 13(3%) and unsatisfied demand /family planning clients who use contraceptive methods other than LAPMs and wants no more child in the future was 89(22.4%).



**Fig.5: - Demand for LAPMs, East Shoa zone, Batu town, May 2009.**

## 5.5 Factors affecting demand for LAPMs

### 5.5.1 Socio demographic factors

Socio demographic factors like age, religion, occupation, educational status and number of live children (parity) were assessed for the presence of association with demand for LAPMs. Age and parity were found to have significant association with demand for LAPMs.

**Table 5: - Association between socio-demographic factors and demand for LAPMs, East Shoa zone, Batu town, May 2009**

Variables	Demand for LAPMs		Crude OR (95%CI)	AOR (95%CI)	
	Yes	No			
<i>Socio demographic factors</i>					
Age group of participants (398)					
	18-24	34	162	1.00	1.00
	25-29	41	114	1.71(0.99 – 2.96)	2.96(0.89-10.1)

	30-34	8	17	2.24(0.81 – 6.09)	3.19(1.01-10.5) **
	35-49	14	8	8.34(2.98 – 23.85)**	5.39(1.29-22.4) **
Religion (398)	Orthodox	59	123	1.00	1.00
	Muslim	13	97	0.28(0.14 – 0.56)**	2.71(0.22-33.0)
	Protestant	24	76	0.66(0.36 – 1.19)	0.64(0.06-7.11)
	Others	1	5	0.42(0.02 – 3.8)	0.91(0.08-10.5)
Occupation (398)	House wife	44	145	1.00	1.00
	Daily laborer	34	59	1.9(1.07 – 3.38)**	3.36(0.26-43.8)
	Merchant	5	35	0.47(0.15 – 1.36)	4.68(0.19-111)
	Student	1	29	0.11(0.01 – 0.82)**	1.30(0.09-18.0)
	Gov. employee	8	20	1.32(0.49 – 3.44)	10.0(0.64--157)
	Unemployed	3	10	0.99(0.21 – 4.14)	21.3(0.65-701)
	Others	2	3	2.2(0.25 – 16.8)	2.93(0.15-56.5)
Educational Status (398)	Illiterate	32	87	1.00	1.00
	1-6 <sup>th</sup> grade	34	90	1.03(0.56 – 1.88)	4.09(0.56-30.6)
	7-12 <sup>th</sup> grade	23	102	0.61(0.32 – 1.17)	2.23(0.31-16.0)
	+ 12 <sup>th</sup> grade	8	22	0.99(0.51 – 1.92)	3.80(0.57-26.0)
Number of alive children (398)	0	1	30	1.00	1.00
	1-3	60	240	7.5(1.06 – 150)**	51.3(5.46-480) **
	4-12	36	31	34.84(4.6 - 725)**	5.85(2.68-12.8) **

P-value<0.05 Adjusted for socio demographic, quality related, knowledge and partner influence and \*\* Indicates those with significant association.

Women with age group of 30-34 had approximately three times higher demand than younger one (odds ratio 3.19 95%CI 1.01-10.5) and women age group of 35-49 tend to have five times higher demand than 18-24 years old (odds ratio 5.39 95%CI 1.29-22.4). Number of live children was found to be an important predictor of demand for LAPMs. Those with 1-3 children have 51 times (odds ratio 51.3 95%CI 5.46-480) and those with 4-12 children have six times (odds ratio 5.85 95%CI 2.68-12.8) higher demand than who have no child. (See table 5)

## 5.5.2 Knowledge and myths

Knowing any of LAPMs (general knowledge about LAPMs) does not have significant association with demand. On the other hand, clients who heard myths were about three times higher demand than who did not heard (odds ratio 2.55 95% CI 1.43-4.88).

## 5.5.3 Service quality

### 5.5.3.1 Counseling, communication skill, interpersonal relation and follow up

Determinants of service quality like counseling, technical competence, interpersonal relation, follow up and method mix were assessed for the presence of an association with demand for LAPMs and some of them had a significant relation.

Clients who were asked by the provider about reproductive intention were found to have less demand than who are not asked (odds ratio 0.32 95%CI 0.18-0.57) Regarding giving appropriate information on the method accepted clients who said the provider explained side effects of method selected have three times higher demand than those who were not told about side effects (Odds ratio 6.5 95%CI 2.09-20.1) as shown in table 6.

**Table 6: - Association b/n Provider counseling, communication skill, interpersonal relation and follow up with demand for LAPMs, East Shoa zone, Batu town, May 2009**

Variables	Demand for LAPMs		Crude OR (95%CI)	AOR (95%CI)	
	Yes	No			
<i>All clients (398)</i>					
Asks client about reproductive intentions: more children?	No	57	113	1.00	1.00
	Yes	40	188	0.42(0.26-0.69)**	0.32(0.18-0.57) **
Client believes the provider will keep her information confidential	No	26	125	1.00	1.00
	Yes	71	176	1.94(1.14 – 3.32)**	1.70(0.99-2.93)
<i>New clients (excludes condom users)(104)</i>					
Mentions HIV/AIDS: method protection?	No	17	45	1.00	1.00
	Yes	11	31	0.94(0.35 – 2.48)	0.81(0.48-1.38)
Discusses dual method use	No	23	48	1.00	1.00
	Yes	5	29	0.36(0.11 – 1.15)	0.47(0.15-1.54)

---

**All clients (398)**

Treats client with dignity/respect

Not well	3	47	1.00	1.00
Very well	94	254	5.8(1.68 - 23.9)**	0.64(0.21-1.89)

Gives instruction on when to return

No	6	15	1.00	1.00
Yes	91	286	0.8(0.28 – 2.37)	0.73(0.25-2.11)

**New clients only (109)**

Gives accurate information on the method accepted

Explains how to use selected method

No	7	11	1.00	1.00
Yes	21	67	0.49(0.15 – 1.63)	0.52(0.16-1.69)

Explains side effects of method selected

No	10	49	1.00	1.00
Yes	18	29	3.04(1.14 – 8.26)**	6.50(2.09-20.1) **

Explains what to do in case of problems

No	11	40	1.00	1.00
Yes	17	38	1.63(0.62 – 4.31)	2.34(0.81-6.52)

---

P-value<0.05 Adjusted for socio demographic, quality related, knowledge and partner influence and \*\* Indicates those with significant association.

## 6. Discussion

In this study it was found that satisfied demand was 3%, unsatisfied demand was 22.4% and total demand was 24.4%. A discrepancy exists between the proportion of women who wish to stop having children (unsatisfied demand) and the proportion who were using LAPM (satisfied demand). Data from demographic and health surveys conducted in sub-Saharan Africa between 2003 and 2005 showed that more than 20% of women in nine of the 11 countries surveyed did not want any more children. However, in each of the nine countries, fewer than 7% of the women were using LAPM. In another nation wide study in Ethiopia, demand for long acting and permanent contraceptive method was 47%. (11,18)

More than half of the study participant, 232(58.3%) have general knowledge (can name at least one LAPMs considered by this study). This is better than 18% showed in the study done in Jinka, Ethiopia. This could be due to clients had better accesses to information than the rural counter part. In our study among LAPMs the most known method was implants that accounts for 218(94%), followed by IUCD 155(49.6%) and

the least known were tubal ligation and vasectomy, 21(9%) and 18(7.8%) respectively. In EDHS 2005, the most known method was implant but surgical methods were better than our study this can be explained by unavailability of these methods in our study area. (4,8). Concerning myths and misconceptions this study only assessed whether clients encountered myths and misconceptions about LAPMs or not. From clients who know about LAPMs who heard myths were 33.2% and specific myths have the potential to harm programs on LAPMs. In another study, which assesses LAPMs in Uganda, showed that most women heard myths and beliefs that could hinder the successful promotion and adoption of the services. (16)

Asking about reproductive intentions before initiation of contraceptive methods is very helpful for the appropriate choice of method and it could help to avoid the dissatisfaction of some clients for whom their choice is not provided. However, our study revealed that 221(55.5%) clients were asked about their reproductive intentions. This is not better than study in Jimma Zone, Ethiopia and Ecuador showed that 34.3% and 63% respectively. (19)

Regarding information given to clients, in this study 165(41.5%), of interviewed and 163(40.9%) of observed clients received information about HIV/AIDS. This is higher than study done in Jimma Zone 24.4% interviewed and only 2.6% observed, although, more than half of women did not get information about HIV/AIDS. 389(97.7%) clients in this study were told when to return for a follow up. This is comparable with studies done in North Gondar zone and Mekelle town showed 81.4% and 97.5% respectively. (19,20,21)

A majority of clients in this study 89(81.7%) were informed about injectable 63(57.7%) about pill, and 49(44.9%) about IUD and 55(50.5%) about implant. Injectables and pills were the most commonly discussed methods to new clients by the providers which may give clients restricted choices. Although, they have several advantages, surgical methods and condom were neglected during the discussion time and those who need them might not be aware of the possibility of having such chances. Similarly, in the study done in Mekele among new clients the majorities

were informed about injectable 97.5% followed by pill 92.6%, implants 48.7%, IUCD 46.3%, female sterilization 19.5% and male sterilization 12.2%. While the rest clients were received information on the method that they asked about. In the Jimma study more than two methods were explained for 33.8% clients. (19,20)

Unless there are contraindications, clients should have the method they want. In this study most 89(81.7%) of new clients received the method they preferred. This shows better freedom on the method of choice. The reasons for not getting their method of preference was 3(20%) because preferred method was contraindicated, 6(40%) because they changed their mind after listening the provider and 6(40%) because provider recommended another method. On the other hand study done in North Gondor showed that 74.1% of the FP clients said that they chose the methods with the assistance of the provider while in 22.4% of the cases the provider by himself/herself selected the method. In the Jimma study among the reasons for not providing the client's choice, unavailability was told to 84.6%, contraindication to 6.5% and necessity of paying 3.00 birr for DMPA to 8.9% clients. (19,21)

Among all married clients (367) participated in this study 341(92.9%) discussed with their partner about their method preference. Of those who discussed with their partners, 21(6.2%) accepted their partner's preference. Though, there was better discussion between partners, significant number of husbands forced their wives to choose what they prefer. A study done in Bangladesh by The ACQUIRE project showed, most acceptors reported that the final decision to have an IUD was made by the client herself 58.5% or by the client with her husband 24.2%; however, 10% reported that the service provider made the decision. (22)

Contraceptive methods received by clients at the study period were dominated by injectables. Of all clients who received contraceptive methods 276(69%) receive injectables, 107(27%) pill, 10(3%) implants and 2 (1%) condoms. This is comparable with DHSE 2005 said that the most widely used method was injectable followed by pill. LAPMs are convenient for users and effectively prevent pregnancy. They are also cost effective for programs over time. Despite their advantages most studies showed that the use of long acting and permanent methods were very low in Ethiopia. (8, 9)

In our study, of all clients in the survey, 392(98.5%) said that waiting time was acceptable. Among those who respond about what they feel concerning waiting time 361(90.7%) said waiting time was reasonable or minimal. A study done in Mekele showed the average waiting time to get service was 36.2( $\pm$ 3) minutes and 112 (89.6%) clients were satisfied with length of waiting time and the rest 13(10.4%) were dissatisfied. Though levels of satisfaction with waiting time is relative, it is found to be one potential area that affects clients' satisfaction with the service provided that needs consideration. (20)

This study revealed several constraints on provision of family planning service because of poor facility set up especially in private medium clinics. Both trained staff and equipments or supplies were not fully available to give quality care. Regarding contraceptive methods only one method was available in all private medium clinics, which gives no choices for clients. Among LAMPs, IUD and implants were available in health center, FGAE clinic and private hospital. Except the private hospital no one facility has the material as well as trained staff to provide voluntary surgical contraceptive methods.

Some socio demographic factors in this study were significantly associated with demand for LAMPs. Regarding age; women with age group of 30-34 had approximately three times higher demand than younger one (odds ratio 3.19 95%CI 1.01-10.5) and women age group of 35-49 tend to had five times higher demand than 18-24 years old (odds ratio 5.39 95%CI 1.29-22.4). Number of live children was found to be an important predictor of demand for LAPMs. Those with 1-3 children had 51 times (odds ratio 51.3 95%CI 5.46-480) and those with 4-12 children had six times (odds ratio 5.85 95%CI 2.68-12.8) higher demand than those who had no child. A study done in Jinka showed various socio demographic and other factors found to be significantly associated with LAPMs use. Knowledge on LAPMs was found to be an important predictor of LAPMs use (OR: 145.6 (29.03-730.2)). Moreover, people in the age group of 25-34 (OR= 6.51 (1.44-29.49)) and 35-49 (OR=6.22 (1.28-30.36)) were more than six times users of LAPMs compared to those in the age group of 15-24. (13)

The lack of discussion about the effect and use of long-term methods on fertility as well as poor understanding of the procedures, would not allow clients to understand

the actual side effects (not rumors) and know the measures that could be taken to avoid or minimize these side effects and seek solutions in case of problems. Lack of such information may enhance method discontinuation and led to the fuelling of myths and beliefs that hinder the successful promotion and adoption of the services. In our study significant number of clients, 77(33.2%) encountered myths and misconceptions about LAPMs, particularly about IUDs and implants. (16)

Family planning service quality related factors like: counseling and communication skill, interpersonal relation, follow up and method selection tested for the presence of association with demand for LAPMs, and found to be significantly affect demand. Among quality determinants provider ask about reproductive intention, and the provider explained side effects of method selected were statistically significant association with demand for LAPMs (p-value < 0.05). A study done on family planning service quality and IUD use in Egypt showed that service quality is an important determinant of use of clinical contraceptive methods in Egypt. Improving quality of family planning services may help further increase use of clinical contraceptive methods and reduce fertility. (23)

## **7. Strength and Limitation**

### **Strengths of the Study**

- Different types of data collection instruments were used to collect data from different sources to increase validity of the study.
- Qualified data collectors (health professionals) were used for observation during client-provider interaction.
- This study is one among the few studies, which assess demand for LAPMs.

### **Limitations of the study**

- Since the study was institutional based, that might undermine generalizing the result to the general population.

- The study is conducted only in the town that doesn't represent the great majority of the rural community.
- Lack of adequate literatures in Ethiopian situation, which prevents further elaborating the discussion
- As any cross sectional study cause and effect relationship was not possible to establish for the factors dealt in the study for it is difficult to determine which factor occurred first.
- Courtesy bias, where respondents' answers may be based on what they think the researcher want to hear may not be completely eliminated although efforts were made to explain that only genuine answers would help achieve the objectives of the study.

## 8. Conclusion

The use of LAPMs has not kept pace with that of short-acting methods, such as oral contraceptives and injectables. In this study the proportion of women currently using LAPMs (3%) is significantly lower than the proportion using short-acting methods.

A discrepancy exists between the proportion of women who wish to stop having children and the proportion who are using LAPM. Satisfied demand /current LAPMs user in six SDPs were 3% and unsatisfied demand /family planning clients who use contraceptive methods other than LAPMs and wants no more child in the future was 22.4%, making the total demand 24.4%.

Many potential clients in our study area lack information or had misconceptions about LAPMs. Myths and misconceptions were also widespread for these methods.

Women and couples who want safe and effective protection against pregnancy would benefit from access to more contraceptive choices, including long-acting and permanent methods (LAPMs), but in our study area no one private medium clinic had these methods, and not all these methods were provided in other SDPs. Among LAMPs surgical methods did not provided in any of SDPs. No adequate trained staff was available in each SDPs.

This study had demonstrated that there were several aspects of socio demographic and family planning service quality related factors found to be significantly associated with demand for LAPMs. So that multi dimensional measures are needed to improve the quality of family planning services, and efforts are needed to meet the unsatisfied demand.

## **9. Recommendation**

As this project shows there were numerous quality issues and other factors that affect demand for LAPMs in the study area. To ensure the quality of services and address the different contraceptive needs of clients:

- 1) The services should be made more widely available and supply stocks should be maintained and replaced speedily.
- 2) Service providers should be trained in order to improve:
  - a) The quality of provider interaction (information provision and counseling) with clients,
  - b) Providers' knowledge and understanding of the methods and procedures,
  - c) Staff competence in performing the procedures,

- 3) Services should be convenient to the clients taking into careful consideration the personal needs of clients such as confidentiality and respect.
- 4) Strengthening the IEC campaign, removing myths and disseminating correct and detailed information about LAPMs is critical. Printed materials should be made available to clients so that they can take them home. This will stimulate discussions among spouses and help build mutual support for the methods.
- 5) FMOH and regional health bureau should motivate and attract NGOs working with LAPMs since there is a need to use LAPMs by most people.
- 6) Conducting further research: - Detailed and large study which considers policy and supply factors, NGOs perspective, service providers and health service managers views on similar issues should be conducted.

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# 11. Appendixes

## 11.1 Annex 1 Structured questionnaire for Client Exit Interview Addis Ababa University School of Public Health

### INTRODUCTION

Good morning/afternoon. My name is

---

I am working for Addis Ababa University. I am a member of a research group working in Orommya region, East Shoa Zone, Batu town. We are studying demand for long acting and permanent contraceptive methods and associated factors by asking clients who came for the service. Based on the information what you give us and other related information the result of this study will help to develop a better family panning service in the country by working with ministry of health, East Shoa zone health office, Orommya region and other responsible bodies.

Your truth full answers for all of our questions about family planning service will be very important to know the conditions of long acting and permanent contraceptive methods and

associated factors in Batu town. Your answers will be confidential and secret. You may also stop the interview at any time. If you decide that you do not want to participate in the study, or that decide at any time in the future you do not want to participate; it will not affect the services you receive at the clinic now or in the future. We appreciate if you try to answer all the questions. If you agree to be interviewed, we will go 15 minutes for us to complete the questionnaire. If you have any questions about the study you can ask.

Thank you. Next I will read a consent, which assures your interest to participate.

---

---

## CONSENT FORM

The researcher explained the aim of the study and to decide any time if I do not want to participate. So I assure that my interest to participate in this study is truly from my knowledge.

*If client refuses to be interviewed, please check this box*

**Signature of Person administering consent** \_\_\_\_\_

**Date** \_\_\_\_\_

**Client's Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

**Identification number:** \_\_\_\_\_

**Interviewer (Name & Number):** \_\_\_\_\_

**01, Health Facility (Name & Number):** \_\_\_\_\_

**02, District (Name & Number):** \_\_\_\_\_

**03, Region (Name & Number):** \_\_\_\_\_

**04, Date of interview: Day \_\_\_\_\_ Month \_\_\_\_\_ Year \_\_\_\_\_**

### 05, Type of Facility Where Interview Took Place

1. Referral Hospital

2. Hospital

3. FP Clinic

4. Higher clinic

5. Health Center

6. Medium clinic

Other(88) \_\_\_\_\_

### 06, Type of Sector:

1. Government

2. Private

3. NGOs

Other (88) \_\_\_\_\_

### 07, Locality of Facility

1. Urban

2. Rural

3. Peri-urban

## Section I. Scio demographic characteristic

1. How old were you at your last birthday? \_\_\_\_\_  (99) Do not now
2. How is your marital staus?  
 1.Single  2.Married  
 3.Divorced  4.Widowed
3. What is your religion?  
 1.Muslim  2.Orthodox Christians  
 3.Protestant  Others (88) \_\_\_\_\_
4. What is your occupational status?  
 1.House wife  2.Government employee  
 3.Daily laborer  4.Merchant  
 5.Student  6.Unemployed  
 Others(88) \_\_\_\_\_
5. What is the highest level of school that you attended?  
 1] Illiterate  2]1-6 grade  3]7-12 grade  4] +12 grade

## Section II. Questions on demand and associated factors

1. Have you ever visited this site for family planning services before today?  
 Yes  No
2. What was the reason for your visit today?  
*Probe until you are able to classify the main reason for the client's visit*  
 1.Get information and/or counseling  
 2.Get prescribed or referred  
 3.Start new contraceptive method use  
 4.Get supplies for method already using or have a routine follow-up visit  
 5.Restart same method  
 6.Switch contraceptive methods or restart a different method  
 7.Discuss a problem about contraceptive
3. Are you using/were you last using (in the past 6months)? If no go to Q# 10  
 1.Yes  2.No
4. If Yes, which method?  
 1.Pill  7.Injectable  
 2.IUD  8.Implant  
 3.Female sterilization  9.Condom  
 4.Spermicide  10.Abstinence  
 5.LAM  11.Diaphragm

6.Rhythm/periodic  
 Other(88) \_\_\_\_\_

12.Condom + other \_\_\_\_\_

5. Did the provider ask if you were having a problem with the method (Probe: or did you mention a problem)? (for continuing clients if not go to Q# 10)  
 1.Yes       2.No
6. Have you had a problem with your method (Probe: that you wanted to discuss with your provider)?  
 1.Yes       2.No
7. Did the provider try to understand the nature of your problem?  
 1.Yes       2.No
8. Did the provider suggest what you should do (action you should take) to resolve the problem?  
 1.Yes       2.No
9. Were you satisfied with the advice or treatment that you received for your problem?  
 1.Yes       2.No
10. Do you come here today to obtain a specific contraceptive method? If no go # 12  
 1.Yes       2.No

**11. Which method did you want when you came here? (PROBE: Before your consultation, did you have a specific method in mind?)**

- |   |  |
|---|--|
| <input type="checkbox"/> 1.Pill                 | <input type="checkbox"/> 7.Injectable            |
| <input type="checkbox"/> 2.IUD                  | <input type="checkbox"/> 8. Implant              |
| <input type="checkbox"/> 3.Female sterilization | <input type="checkbox"/> 9.Condom                |
| <input type="checkbox"/> 4.Spermicide           | <input type="checkbox"/> 10.Abstinence           |
| <input type="checkbox"/> 5.LAM                  | <input type="checkbox"/> 11.Diaphragm            |
| <input type="checkbox"/> 6.Rhythm/periodic      | <input type="checkbox"/> 12.Condom + other _____ |
| <input type="checkbox"/> Other(88) _____        |  |

**12. Have you discussed with your partner about which method to use? If she has partner. If no go # 14**

1.Yes       2.No

**13. What was your partner opinion?**

- 1.Force you to choice a method what he want
- 2.Decide together

**14. Which methods did the provider discuss with you?**

- |   |  |
|---|--|
| <input type="checkbox"/> 1.Pill                 | <input type="checkbox"/> 7.Injectable  |
| <input type="checkbox"/> 2.IUD                  | <input type="checkbox"/> 8. Implant    |
| <input type="checkbox"/> 3.Female sterilization | <input type="checkbox"/> 9.Condom      |
| <input type="checkbox"/> 4.Spermicide           | <input type="checkbox"/> 10.Abstinence |
| <input type="checkbox"/> 5.LAM                  | <input type="checkbox"/> 11.Diaphragm  |
| <input type="checkbox"/>                        | <input type="checkbox"/>               |

6.Rhythm/periodic  12.Condom + other \_\_\_\_\_  
 Other(88) \_\_\_\_\_

**15. Do you know about LAPMs contraceptive methods ? Before your consultation.**

**If no go to # 18**

1.Yes  2.No

**16. Which LAPMs do you know?**

1. IMPLANT  3.IUD  
 2.FEMALE STERILIZATION  4.VASECTOMY

**17. Have you heard myths and beliefs in the community about the above methods?**

1.Yes  2.No

If yes please specify

IMPLANT \_\_\_\_\_

FEMALE\_STERILIZATION\_\_\_\_\_

IUD\_\_\_\_\_

VASECTOMY\_\_\_\_\_

**18. Did you receive a contraceptive method today? If yes go to # 20**

1.Yes  2.No

**19. Were you given a prescription or a referral for a method today? If no go to # 26**

1.Yes, prescribed a method  2.No.  3.Yes, referred for a method

**20. Which method(s) did you receive or were you given a prescription or a referral?**

**(PROBE: Any others?)Mark all that apply.**

1.Pill  7.Injectable  
 2.IUD  8. Implant  
 3.Female sterilization  9.Condom  
 4.Spermicide  10.Abstinence  
 5.LAM  11.Diaphragm  
 6.Rhythm/periodic  12.Condom + other\_\_\_\_\_  
 Other(88)\_\_\_\_\_

**21. Is the above method, what in your mind when you came to the clinic? If yes go to # 23**

1.Yes  2.No

**22. If no, why do you think you did not get (method named in 16)?**

*Mark most important reason only.*

1.Chose not to accept a method at this time  5.Provider recommended  
 2.Preferred method was not appropriate another method  
(contraindications)  6.Cost of method is not affordable  
 3.Changed mind after listening to provider  7..Not available at clinic today.  
 4.Not available at all  8.No appropriate provider

available that day

Don't know/ can't remember(99) Other(specify)(88)\_\_\_\_\_

**23. For the method you just decided to accept, did the provider:**

A. Explain to you how to use the method effectively?  1.Yes  2.No

*Do not ask if method = sterilization*

B. Describe possible side effects?  1.Yes  2.No

C. Tell you what to do if you have any problems?  1.Yes  2.No

D. Explain that this method does not provide protection against STIs and AIDS?  1.Yes  2.No

**24. Are you satisfied with the cost of method you decided to accept?**

1.Yes  2.No  3.Not paid

**25. Were you told when to return for a follow-up visit?**

1.Yes  2.No

**26. Did you feel comfortable to ask questions during the session?**

1.Yes  2.No

**27. Do you feel the information given to you during your visit today was too little, too much, or just about right?**

1.Too little  2.About right  3.Too much  Don't know(99)

**28. Did you have a pelvic exam during your visit today?**

1.Yes  2.No

**29. Did you have enough privacy during your exam? (Probe: Clients or staff, other than those caring for you, could not see you.)**

1.Yes  2.No  Do not now (99)

**30. When meeting with the provider during your visit, do you think other clients could hear what you said? (Note: This does not include the outside observer.)**

1.Yes  2.No  Do not now (99)

**31. Do you believe that the information that you shared about yourself with the provider will be kept confidential?**

1.Yes  2.No  Do not now (99)

**32. During your visit to the clinic how were you treated by the provider?**

1.Very well  2.Well  3.Not very well/ poorly

**33. During your visit to the clinic how were you treated by the other staff?**

1.Very well  2.Well  
 3.Not very well/ poorly  There was no other staff (99)

**34. About how long did you wait between the time you first arrived at this clinic and the time you saw a staff person for a family planning consultation?**

1] <15 minutes  2] 16-30 minutes  3] 31-45 minutes

4] 46-60 minutes      5] 61-90 minutes      6] 91-120 minutes

7] >120 minutes       Don't know(99)

**35. Do you feel that your waiting time was reasonable or too long?**

1.No waiting time  2.Reasonable/ short  3. Too long  Don't know(99)

**36. During your talk with the provider as STIs/AIDS discussed?**

1.Yes       2.No

**37. Did the provider encourage you to use condoms at the same time (Probe:**

simultaneously) as the family planning method you chose or are currently using?

1.Yes       2. No

**38. How many living children of your own do you have? \_\_\_\_\_.**

**39. Would you like to have (a/another) child in the future?**

1.Yes       2.No       3.Depends on husband

4.Depends on god       Don't know(99)

**40. How long would you like to wait from now before the birth of (a/another) child?**

1.Less than two years  2.More than two years  Don't know(99)

**41. Did the provider talk about having another child in the future?**

1.Yes       2.No       3.Do not now

## **11.2 Annex 2. Facility Audit and Manager Survey check list**

**Identification Number:** \_\_\_\_\_

### **Facility Audit and Manager Survey**

**Instructions:** Complete this inventory using observation and discussion with the person in charge of family planning services. Verify the existence of functional equipment and supplies and the condition of the facility through observation. If you cannot observe the equipment, supplies or conditions, then indicate this in the margins.

**Note: The respondent should be the manager of the facility.**

### **BACKGROUND CHARACTERISTICS**

**01. Health Facility (Name & Number):** \_\_\_\_\_

**02. District (Name & Number):** \_\_\_\_\_

**03. Region (Name & Number):** \_\_\_\_\_

**04. Date of interview:** Day \_\_\_\_\_, Month \_\_\_\_\_, Year \_\_\_\_\_.

### **05 Type of Facility Where Observation Took Place**

Referral Hospital       Mobile Health Clinic



A. COMBINED PILLS	Yes	No	Yes	No
B. PROGESTERONE ONLY PILL	Yes	No	Yes	No
C. IUD	Yes	No	Yes	No
D. INJECTABLES	Yes	No	Yes	No
E. CONDOMS	Yes	No	Yes	No
F. SPERMICIDE	Yes	No	Yes	No
G. DIAPHRAGM	Yes	No	Yes	No
H. FEMALE STERILIZATION	Yes	No	Yes	No
I. VASECTOMY	Yes	No	Yes	No
J. IMPLANTS	Yes	No	Yes	No

**3. When you run out of contraceptives, how long does it take to replace them?**

(ASK)

- One week or less                       One month or less  
 Six months or less                       Other \_\_\_\_\_  
 Don't know

**4. From LAPMs which methods are offered at this facility?**

*For each method, first record if it is provided, and then record whether the service has been available at all times in the last six months. If the service has NOT been available at all times in the last six months, mark the reason why it was last not available and record the length of time it was not available. (OBSERVE AND ASK)*

Type of methods	Provided	Available at all times in last 6 months	If no, reason not available last time
A. FEMALE STERILIZATION	Yes    No	Yes    No	1. Supplies not available 2. Equipment not available 3. Trained staff not available 4. Other _____

B. VASECTOMY	Yes	No	Yes	No	1. Supplies not available 2. Equipment not available 3. Trained staff not available 4. Other _____
C. IMPLANTS	Yes	No	Yes	No	1. Supplies not available 2. Equipment not available 3. Trained staff not available 4. Other _____
D. IUD	Yes	No	Yes	No	1. Supplies not available 2. Equipment not available 3. Trained staff not available 4. Other _____

**5. When you are unable to perform the above methods, how long does it take for them to resume?(ASK)**

- One week or less                       One month or less  
 Six months or less                       Other \_\_\_\_\_  
 Don't know

**6. Which of the following types of equipment are available and in working order?**

*Ask to see each type of equipment. If there is at least one available in working order, mark the corresponding box on the table. (Note: many items will be found in "minilap kits," "IUD kits," or "no-scalpel vasectomy kits.")*

**(OBSERVE AND ASK)**

**EQUIPMENT AND SUPPLIES (MARK IF AT LEAST ONE IS AVAILABLE)**

1. Flashlight 2. Working lamp 3. Scale 4. Blood pressure gauge 5. Thermometer 6. Stethoscope 7. Scissors 8. Sterile needles and syringes 9. Specula 10. Tenacula 11. Uterine sound 12. Alligator forceps 13. Sponge holding forceps 14. Artery forceps 15. Dressing forceps	25. Tubal hook 26. Sharp trocars 27. Sterilizers 28. Iodine 29. Xylocaine or lignocaine 30. Antiseptic 31. Chlorine solution 32. Sterile gloves 33. Disposal containers for contaminated waste/supplies 34. Sharps containers for used sharps 35. Plastic buckets or containers for decontamination 36. Clean instrument containers 37. Instrument trays
---	--



**(OBSERVE OR ASK)**

Type Of Material	Yes	No
A. Posters		
B. Flip Chart		
C. Brochure/Pamphlet (at least 10)		
D. Information Sheet (at least 10)		
E. Job Aids		
F. Counseling cards		
G. Other (specify) _____ _____		

**Section IV Supervision**

**12. What was the date of the last “outside” supervisory visit, which included a review of family planning services? (OBSERVE OR ASK)**

Month \_\_\_\_\_, year \_\_\_\_\_

**Section V Training**

**13. Reproductive health focused trainings taken by Family planning service providers (ASK)**

S.No	Qualification	Type of training	Duration of training
1			
2			
3			

4			
---	--	--	--

**Section VI Protocols and Guidelines**

**14. Please show me the most recent version of written guidelines and protocols for delivering family planning services.**

*Record "yes" if at least one set of written guidelines is available. (OBSERVE AND ASK)*

Available and observed (record date of version)\_\_\_\_\_

Available, but not observed                       Not available

Don't know

**15. Please show me where all of the client records are kept.**

*Record "yes" if client records are kept in a secure area. (OBSERVE AND ASK)*

Yes                       No                       Don't know

**Section VII Use of Information in Clinic Management**

**16. What methods do you have for determining client opinions?**

*Read options and mark all that apply. (ASK)*

1. Yes (mark the specific method below)

- A. Client suggestion box
- B. Provider asks client
- C. Other staff asks client
- D. Other \_\_\_\_\_

2. No method available (*go to #18*)

**17. In the past quarter (3 months), have any changes been made in the program based on**

**feedback from clients? (ASK)**

Yes                       No(*Go to question #19*)

Don't know (*Go to question #19*)

**18. What changes have taken place? (ASK)**

**EXPLAIN**\_\_\_\_\_

---

---

**19. What methods do you have for determining provider opinions?**

*Read options and mark all that apply. (ASK)*

1. Yes (mark the specific method below)
  - A. Staff suggestion box
  - B. Staff meetings
  - C. Internal clinic evaluations
  - D. Other \_\_\_\_\_

2. No method available (*go to #21*)

**20. In the past quarter (3 months), have any changes been made as a result of provider opinions. (ASK)**

- Yes       No(*Go to question #22*)  
 Don't know (*Go to question #22*)

**21. What changes have taken place? (ASK)**

EXPLAIN \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Section VIII Service Statistics**

**22. How many clients received family planning services in the last 4 completed quarters (12 months)? (OBSERVE OR ASK)**

- A. TOTAL NEW FAMILY PLANNING ACCEPTORS \_\_\_\_\_
- B. TOTAL FP VISITS \_\_\_\_\_

**23. Overall, how many client visits for MCH, FP, and general exams were recorded at this clinic in the last 4 completed quarters (12 months)? (OBSERVE OR ASK)**

\_\_\_\_\_ #

**24. How many clinical service providers are usually available to see family planning clients?(ASK)**

\_\_\_\_\_ #

### 11.3 Annex 3. Observation checklist for Counseling and Clinical Procedures

Observation ID number: \_\_\_\_\_

01, Health Facility (Name & Number): \_\_\_\_\_

02, District (Name & Number): \_\_\_\_\_

03, Region (Name & Number): \_\_\_\_\_

04, Provider (Name & ID Number): \_\_\_\_\_

05, Date of Observation: Day\_\_\_\_\_, Month\_\_\_\_\_, Year\_\_\_\_\_.

06, Observer (Name & Number): \_\_\_\_\_

07, Type of Facility Where Observation Took Place:

Referral Hospital

Mobile Health Clinic

Hospital

Clinics in Non-permanent Facilities Clinic  
(schools, rotating rural health outposts, etc.)

FP Clinic

Health Center

Health Post

Other\_\_\_\_\_

08, Type of Sector:

Government

Private

NGOs

Other

**09, Locality of Facility:**

Rural                       Urban                       Peri-urban

**10, Time Observed Session Began: \_\_\_\_:\_\_\_\_ (Use local time)**

**11, Provider providing MOST of the Counseling session:**

Nurse                       Nurse- Midwife                       Doctor

Other \_\_\_\_\_

**12. Sex of Provider:**

Female                       Male

**Counseling Observation checklist**

*FOR ALL CLIENTS Mark (X) as appropriate*

**20. Family planning status upon arrival at this facility:**

Non-user, but past use                       Current user  
 Non-user, no past use                       Not determined

**21. Previous contact with provider:**

Yes                       No                       Not determined

22. Did the provider:	Yes	No
A. Ask open-ended questions		
B. Encourage client to ask questions		
C. Treat client with respect		
D. See client in private		
E. Discuss a return visit		
F. Ask client her concerns with any method		

G. Use visual aids		
H. Use client record		
I. Assure client of confident		

<b>23. Information Discussed:</b> Mark who initiated the conversation or mark "not discussed"	Provider asked	Client provided	Not discussed
A. Current age			
B. Marital/ relationship status			
C. Number of living children			
D. Desire for more children			
E. Timing of next child			
F. Current pregnancy status			
G. History of pregnancy complications			
H. Partner's attitude about FP (approve/disapprove)			
I. Multiple/single sexual partner(s)			
J. Partner multiple/single sexual partner(s)			
K. HIV/AIDS and STIs discussed			
L. History/signs/symptoms of STIs			

**24. Method actually received / prescribed (new clients) or came/left with (continuing clients):**

- Pill             IUD             Injectable  
 NORPLANT    Female sterilization    Condom  
 Spermicide    Rhythm/periodic    abstinence  
 LAM             Diaphragm        Condom + other \_\_\_\_\_  
 Other \_\_\_\_\_

**NEW CLIENTS ONLY**

Mark (X) as appropriate

**25. Client stated preference for method:**

- Pill             IUD             Injectable  
 NORPLANT    Female sterilization    Condom  
 Spermicide    Rhythm/periodic    abstinence  
 LAM             Diaphragm        Condom + other \_\_\_\_\_  
 Other \_\_\_\_\_

**26. Preferred method received:**

Yes       No

**27. Provider determined client's reason for method selection:**

Yes       No

MARK ONLY IF CLIENT DID NOT RECEIVE PREFERRED METHOD	
<b>28. Reason preferred method not received:</b>	<b>(X)</b>
A. Not available in clinic that day	
B. Not available at all	
C. Not available, referred to another source or clinic	
D. Not appropriate method (contraindications)	
E. No appropriate provider available that day	
F. Provider recommended another method	
G. Changed mind after listening to provider	
H. Client did not make choice at time of session	
I. Client not at risk of pregnancy	
J. Pregnancy suspected	
K. Told to return during menses	
L. Client could not pay for services today	
M. Other _____	
N. Not clear why	

<b>29. Provider gave accurate information about key point:</b>	Yes	No
A. How to use		
B. Side effects		

<b>30. Did the provider:</b>	Yes	No
A. Explain method does not protect against STIs and AIDS		
B. Encourage use of condoms as 2 <sup>nd</sup> method		

**Clinical Observation**

**40. Clinical provider same person who provided counseling:**

Same person (go to Q43)       Different person

**41. Provider performing MOST of clinical examination:**

Nurse       Nurse- Midwife       Doctor  
Other \_\_\_\_\_

**42. Sex of Provider:**

Female     Male

<b>43. Observation conducted for:</b>	Yes	No
B. Client underwent pelvic exams – if yes, complete section A		
C. Client had an IUD inserted – if yes, complete section B		

**A. Pelvic Exams**

Did the provider:	Yes	No
P-1. Ensure client has privacy		
P-2. Prepare all instruments before exam		
P-3. Wash hands before exam		
P-4. Use sterilized or high-level disinfected instruments for each exam		
P-5. Put on new or disinfected gloves before exam		
P-6. Inspect the external genitalia		
P-7. Ask the client to take slow, deep breaths, and relax all muscles		
P-8. (If used) Explain speculum insertion procedure to client		
P-9. Inspect the cervix and vaginal mucosa		
P-10. Perform bimanual exam gently and without discomfort to client		
P-11. Ensure that instruments and reusable gloves are decontaminated		

**B. IUD Insertion**

Did the provider:	Yes	No
I-1. Ensure client has privacy		
I-2. (NEW CLIENT) Reconfirm client's method choice		
I-3. Use sterilized or high-level disinfected instruments		
I-4. Wash hands before putting on gloves		
I-5. Glove hands		
I-6. Conduct speculum exam for RTI/STIs before bimanual exam		
I-7. Conduct bimanual pelvic exam		
I-8. Visualize cervix during cleaning		
I-9. Use tenaculum		
I-10. Sound the uterus before IUD insertion		
I-11. Use the no-touch technique for inserting the IUD		
I-12. Wash hands after removing gloves		
I-13. Ask client to wait/rest for at least 15 minutes after insertion		

I-14. Wipe contaminated surfaces with disinfectant		
I-15. Ensure that instruments and reusable gloves are decontaminated		

#### 11.4 Annex 4. Client Exit Interview Amharic Translated

አዲስ አበባ ዩኒቨርሲቲ የጤና አጠባበቅ ትምህርት ቤት

**የጥናት መረጃ መስጫ**

**መግቢያ**

ጤና ይስጥልኝ ስሜ \_\_\_\_\_ ይባላል። የምሰራው ለአዲስ አበባ ዩኒቨርሲቲ የጤና አጠባበቅ ትምህርት ቤት ነው። በኦሮሚያ ክልል በምስራቅ ሸዋ ዞን በባቱ ከተማ ለረጅም ጊዜና በቀሚነት ስለ ሚያገለግሉ የወሊድ መቆጣጠሪያ ዘዴዎች ለማጥናት በተዋቀረው ቡድን ውስጥ አባል ነኝ። በጥናታችን ውስጥ በጤና አገልግሎት መስጪያ ቤቶች ውስጥ ለአገልግሎት የሚመጡትን ተጠቃሚዎች በመጠየቅ የቤተሰብ ምጣኔ አገልግሎትን ጥራት ማጥናትን አካተናል። እርሶ የሚሰጡን መረጃ ከሌሎች የመረጃ ምንጮች ጋር ተዳምሮ በሚሰጠን ውጤት መሠረት ከሚመለከቱት የጤና ባለስልጣናት፣ ከጤና ጥበቃ፣ ከምስራቅ ሸዋ የጤና መምሪያና ከኦሮሚያ የጤና ቢሮ ጋር በመወያየት በአካባቢው የቤተሰብ ምጣኔ አገልግሎት የሚሻሻልበትን ሁኔታ ለማመቻቸት ታልሞ የተዘጋጀ ጥናት ነው።

የቤተሰብ ምጣኔ አገልግሎቱን በተመለከተ ለምንጠይቆት ጥያቄዎች የሚሰጡን ትክክለኛና ቀና መልስ በባቱ ከተማ ውስጥ ለረጅም ጊዜና በቀሚነት ስለሚያገለግሉ የወሊድ መቆጣጠሪያ ዘዴዎች በሚገባ ለመረዳት ወሳኝ ሚና አለው።

በዚህ መጠይቅ ውስጥ ስምትንና እርሶን ለመለየት የሚያገለግል ነገር አይባድም። መመለስ ያልፈለጉትን ጥያቄ እንዲመልሱ አይገደዱም። በሂደት ውስጥ በጥናቱ ላለመካፈል በማንኛውም ወቅት ለመወሰን ይችላሉ። አስገዳጅ ሁኔታ ውስጥ አይገቡም። በጥናቱ ውስጥ ላለመካፈል በሚወስኑበት ወሳኔ የተነሳ የሚደርስበት አንዳችም ሁኔታ የለም። የሚያገኙትን የጤና አገልግሎትም አያስጓጉልም። ነገር ግን ሁሉንም ጥያቄዎች እንዲመልሱልን እናበረታታለን። ከላይ እንደጠቀስነው የሚሰጡንን መረጃ የቤተሰብ እቅድ አገልግሎትን ጥራት ለመረዳት ከፍተኛ እገዛ ያደርጋል። ጥያቄዎቹ ከ15 ደቂቃ በላይ አይወስዱም። እናም ጥያቄዎቹን ለመመለስ ለሚያደርጉልኝ እገዛ በቅድሚያ አመሰግናለሁ። ግልፅ ያልሆነ ነገር ካለ ሊጠይቁን ይችላሉ።

ስለትብብር በጣም አመሰግናለሁ። ከዚህ ቀጥሎ በጥናቱ ለመሳተፍ መስማማቱን ለማረጋገጥ የሚከተለውን የስምምነት ቅጽ አነብሎታለሁ።

**የስምምነት ቅጽ**

ተመራማሪው የጥናቱን ዓላማ በሚገባ አስረድተውኛል። በተጨማሪም በጥናቱ ያለመሳተፍና በማንኛውም ጊዜ ለማቋረጥ ያለኝን መብት ገልጽውልኛል። በዚህም መሠረት በጥናቱ ለመሳተፍ ሙሉ ፈቃደኛ መሆኔን አረጋግጣለሁ።

ተጠያቂው ተስማምቷል?  አዎ  አልተስማማም

የጠያቂው ፊርማ \_\_\_\_\_ ቀን \_\_\_\_\_

የተጠያቂው ፊርማ \_\_\_\_\_ ቀን \_\_\_\_\_

አዲስ አበባ ዩኒቨርሲቲ የጤና አጠባበቅ ትምህርት ቤት

የጠያቂው ስም /ቁጥር/ \_\_\_\_\_

1. የጤና ድርጅቱ ስም \_\_\_\_\_

2. ወረዳ \_\_\_\_\_

3. ክልል \_\_\_\_\_

4. ቃለ መጠየቁ የተደረገበት ጊዜ / \_\_\_\_\_ / \_\_\_\_\_ (ቀን/ወር/ዓ.ም)

5. የጤና ድርጅቱ ዓይነት

- 1. ራፈራል ሆስፒታል  2. ሆስፒታል
- 3. የቤተሰብ ምጣኔ ክሊኒክ  4. ከፍተኛ ክሊኒክ
- 5. ጤና ጣቢያ  6. መካከለኛ ክሊኒክ
- ሌሎች(ይገለፅ)(88) \_\_\_\_\_

6. የጤና ድርጅት ክፍል

- 1. የመንግስት  2. የግል

3.መንግስታዊ ያልሆነ(መያድ) ሌላ(ይገለፅ)(88) \_\_\_\_\_

7. ጤና ድርጅቱ የሚገኝበት ቦታ

- 1.ከተማ
- 2.ገጠር
- 3.የገጠር ከተማ

**ክፍል አንድ**

**የማህበራዊና ዲሞክራሲያዊ ሁኔታዎች**

1. ዕድሜዎ ስንት ነው? \_\_\_\_\_  (99) አላውቅም

2. የጋብቻ ሁኔታ

- 1.ያላገባች
- 2.ያገባች
- 3.የተፋታች
- 4.ባሏ የሞተባት

3. ሃይማኖትዎ ምንድነው?

- 1.እስላም
- 2.ኦርቶዶክስ ክርስቲያን
- 3.ፕሮቴስታንት
- ሌላ (ይገለፅ)(88)\_\_\_\_\_

4. የስራ ሁኔታ

- 1.የቤት እመቤት
- 2.የመንግስት ሰራተኛ
- 3.የቀን ሰራተኛ
- 4.ነጋዴ
- 5.ተማሪ
- 6.ስራ የሌላት

ሌላ(ይገለፅ)(88) \_\_\_\_\_

5. ከፍተኛው የትምህርት ደረጃዎ ስንት ነው?

- 1.አልተማርኩም
- 2.ከ1-6
- 3.ከ7-12
- 4.ከ12 በላይ

**ክፍል ሁለት**

**በአገልግሎት ጥራት ሁኔታ ላይ የተመሰረቱ ጥያቄዎች።**

1. ከዚህ በፊት እዚህ የጤና ድርጅት የቤተሰብ ምጣኔ አገልግሎት ለመጠቀም መጥተው ያውቃሉ?

- 1.አዎ
- 2.አላውቅም

2.ዛሬ ወደዚህ የጤና ድርጅት የመጡት ምን አይነት አገልግሎት ለማግኘት ነው

- 1.መረጃ ለማግኘትና ለምክክር አገልግሎት
- 2.ለወሊድ መቆጣጠሪያ ዘዴ የማዘዣ ወረቀት ለማግኘትና ለሪፈራል
- 3.አዲስ የቤተሰብ ምጣኔ አገልግሎት ለመጀመር
- 4.እየተጠቀምኩ ያለሁት የቤተሰብ ምጣኔ አገልግሎት አይነት ለመውሰድ
- 5.አቋርጫ የነበረውን የቤተሰብ ምጣኔ አገልግሎት አይነት ለመውሰድ
- 6.ሌላ አይነት የቤተሰብ ምጣኔ አገልግሎት ለመጀመር
- 7.ያለብኝን ችግር ለመወያየት

3. ከዚህ በፊት የቤተሰብ ምጣኔ አገልግሎት ይጠቀሙ ነበር? (ላለፉት ስድስተ ወራት)

**አልጠቀምም ከሆነ ወደ ጥያቄ አስር እሴት**

- 1.አዎ
- 2.አልጠቀምም

4. አዎ ከሆነ የትኛውን አይነት?

- |   |  |
|---|--|
| <input type="checkbox"/> 1.የሚሞጥ ፒል                | <input type="checkbox"/> 7.በመርፌ የሚሰጥ         |
| <input type="checkbox"/> 2.በማህፀን ውስጥ የሚቀመጥ        | <input type="checkbox"/> 8.በክንድ ውስጥ የሚቀበር    |
| <input type="checkbox"/> 3.በቀዶ ጥገና የሚሰራ ዘላቂ (የሴት) | <input type="checkbox"/> 9.ኮንዶም              |
| <input type="checkbox"/> 4.አረፋማ እንክብል             | <input type="checkbox"/> 10.ግንኙነት ማቆም        |
| <input type="checkbox"/> 5.በማጥባት እርግዝናን መከላከል     | <input type="checkbox"/> 11.በማህፀን በር ላይ የሚገባ |
| <input type="checkbox"/> 6.የቆጠራ ዘዴ                | <input type="checkbox"/> 12.ኮንዶም እና ሌላ_____  |
| <input type="checkbox"/> ሌሎች (ይገለፅ)(88)_____      |  |

5. ይወስዱት የነበረው የወሊድ መቆጣጠሪያ ዘዴ ችግር እንደነበረውና እንዳልነበረው ባለሙያው ጠይቆታል? አልጠየቀኝም ከሆነ ወደ ጥያቄ 10 እለፊ

- 1.አዎ                       2.አልጠየቀኝም

6. በሚወስዱት የወሊድ መቆጣጠሪያ ዘዴ ችግር ነበረብዎ?

- 1.አዎ                       2.የለብኝም

7. የጤና ባለሙያው ስለ ችግሮ ለመረዳት ሞክሯል?

- 1.አዎ                       2.አልሞከረም

8. የጤና ባለሙያው ችግሮን ለመፍታት ምን ማድረግ እንዳለቦት ነገሮት?

- 1.አዎ                       2.አልነገረኝም

9. ለችግሮ በተሰጥዎት መፍትሄ እረክተዋል?

- 1.አዎ                       2.አልረከብኩም

10. ዛሬ ወደዚህ የጤና ድርጅት የመጡት አንድ አይነት የወሊድ መቆጣጠሪያ ዘዴ ለመውሰድ ነው? አይደለም ከሆነ ወደ ጥያቄ 12 እለፊ

- 1.አዎ                       2.አይደለም

11. የትኛውን አይነት የወሊድ መቆጣጠሪያ ዘዴ ለመውሰድ ፈልገው መጡ?

( የጤና ባለሙያዉን ከማግኘቱ በፊት የሰቡት ብለስ ጠይቂ )

- |   |  |
|---|--|
| <input type="checkbox"/> 1.የሚሞጥ ፒል                | <input type="checkbox"/> 7.በመርፌ የሚሰጥ         |
| <input type="checkbox"/> 2.በማህፀን ውስጥ የሚቀመጥ        | <input type="checkbox"/> 8.በክንድ ውስጥ የሚቀበር    |
| <input type="checkbox"/> 3.በቀዶ ጥገና የሚሰራ ዘላቂ (የሴት) | <input type="checkbox"/> 9.ኮንዶም              |
| <input type="checkbox"/> 4.አረፋማ እንክብል             | <input type="checkbox"/> 10.ግንኙነት ማቆም        |
| <input type="checkbox"/> 5.በማጥባት እርግዝናን መከላከል     | <input type="checkbox"/> 11.በማህፀን በር ላይ የሚገባ |
| <input type="checkbox"/> 6.የቆጠራ ዘዴ                | <input type="checkbox"/> 12.ኮንዶም እና ሌላ_____  |
| <input type="checkbox"/> ሌሎች (ይገለፅ)(88)_____      |  |

12. ባለቤት ላላቸዉ ብቻ ፤ ከሌላቸዉ ወደ ጥያቄ 14 እለፊ። የትኛውን አይነት የወሊድ መቆጣጠሪያ ዘዴ መውሰድ እንዳለቦት ከባለቤትዎ ጋር ተማክረዋል?

- 1.አዎ                       2.አልተማክርኩም

13. የባለቤትዎ ሀሳብ ምን ነበረ?

- 1.እሱ የመረጠውን የወሊድ መቆጣጠሪያ ዘዴ እንድጠቀም ይፈልጋል
- 2.ስለምርጫዬ ተወያይተን የወሰነው ነው።

14. የጤና ባለሙያው የትኛውን አይነት የወሊድ መቆጣጠሪያ ዘዴ አወያዮት?

- 1. የሚዋጥ ፒል
- 2. በማህፀን ውስጥ የሚቀመጥ
- 3. በቀዶ ጥገና የሚሰራ ዘላቂ (የሴት)
- 4. አረፋማ እንክብል
- 5. በማጥባት እርግዝናን መከላከል
- 6. የቆጠራ ዘዴ
- 7. በመርፌ የሚሰጥ
- 8. በክንድ ውስጥ የሚቀበር
- 9. ኮንዶም
- 10. ግንኙነት ማቆም
- 11. በማህፀን በር ላይ የሚገባ
- 12. ኮንዶም እና ሌላ \_\_\_\_\_

15. ለረጅም ጊዜና ለዘለቄታው ስለሚያገለግሉ የወሊድ መቆጣጠሪያ ዘዴዎች ያውቃሉ?

( የጤና ባለሙያዉን ኮማግኘቶ በፊት ብለስ ጠይቂ ) አላውቅም ከሆነ ወደ ጥያቄ 18 እለፊ

- 1. አዎ
- 2. አላውቅም

16. የትኞቹን የወሊድ መቆጣጠሪያ ዘዴዎች ያውቃሉ?

- 1. በክንድ ውስጥ የሚቀበር
- 2. በቀዶ ጥገና የሚሰራ ዘላቂ(የሴት)
- 3. በማህፀን ውስጥ የሚቀመጥ
- 4. በቀዶ ጥገና የሚሰራ ዘላቂ (የወንድ)

17. ከላይ ስለተጠቀሱት የወሊድ መቆጣጠሪያ ዘዴዎች አጉል እምነቶችና አባባልዎች ሰምተዋል?

- 1. አዎ አዎ ካሉ (ይገለጽ)
- 2. አልሰማሁም

ስለ በክንድ ውስጥ የሚቀበር \_\_\_\_\_

ስለ በማህፀን ውስጥ የሚቀመጥ \_\_\_\_\_

ስለ በቀዶ ጥገና የሚሰራ ዘላቂ (የወንድ) \_\_\_\_\_

ስለ በቀዶ ጥገና የሚሰራ ዘላቂ (የሴት) \_\_\_\_\_

18. ዛሬ የወሊድ መቆጣጠሪያ ዘዴ ወሰዱ? አዎ ከሆነ ወደ ጥያቄ 20 እለፊ

- 1. አዎ
- 2. አልወሰድኩም

19. ዛሬ የቤተሰብ ምጣኔ ዘዴ ማዘዣ ወይንም ራፈራል ተሰጥዎት? 2 ከሆነ ወደ ጥያቄ 26 እለፊ

- 1. አዎ የመዳኒት መዘዣ
- 2. አልተሰጠኝም
- 3. አዎ ራፈራል

20. የትኛውን አይነት የቤተሰብ ምጣኔ ዘዴ ተሰጥዎት ወይንም ለየትኛው አይነት የቤተሰብ ምጣኔ

ዘዴ ማዘዣ ወይንም ራፈራል ተጻፈሎት?

- 1. የሚዋጥ ፒል
- 2. በማህፀን ውስጥ የሚቀመጥ
- 3. በቀዶ ጥገና የሚሰራ ዘላቂ (የሴት)
- 4. አረፋማ እንክብል
- 5. በማጥባት እርግዝናን መከላከል
- 6. የቆጠራ ዘዴ
- 7. በመርፌ የሚሰጥ
- 8. በክንድ ውስጥ የሚቀበር
- 9. ኮንዶም
- 10. ግንኙነት ማቆም
- 11. በማህፀን በር ላይ የሚገባ
- 12. ኮንዶም እና ሌላ \_\_\_\_\_

ሌሎች (ይገለፅ)(88) \_\_\_\_\_

21. ከላይ የገለጹት የወሊድ መቆጣጠሪያ ዘዴ ክቤትዎ አስበው የመጡት ነው? አዎ ከሆነ ወደ ጥያቄ 23 እለፊ

- 1. አዎ
- 2. አይደለም

22. አይደለም ከሆነ፤ ለምን ክቤትዎ አስበው የመጡትን የወሊድ መቆጣጠሪያ ዘዴ አልወሰዱም?

(ዋነኛውን ምክንያት ብቻ ምረጧ)

- 1. ላለመውሰድ ስለወሰንኩ
  - 2. የጤና ባለሙያ ሌላው ሰጧልኝ
  - 3. የጤና ባለሙያውን ሰምቼ አሳቤን ስለቀየርኩ
  - 4. በጤና ድርጅቱ ፈጽሞ ስለሌለ
  - አላውቅም(99)
  - 5. ያሰብኩት የወሊድ መቆጣጠሪያ ዘዴ ለእኔ እንደማይሆን ስለተረዳሁ
  - 6. ዋጋው ስለከበደኝ
  - 7. ዛሬ በጤና በድርጅቱ ስለሌለ
  - 8. ሊሰጠኝ የሚችል ባለሙያ ስለሌለ
- ሌላ ይገለጽ(88) \_\_\_\_\_

23. ስለወሰዱት የወሊድ መቆጣጠሪያ፣ የጤና ባለሙያው...

- ሀ) አጠቃቀሙን ነገርት?  1. አዎ  2. አልነገረኝም
- ለ) የጎንዮሽ ጉዳት እንዳለው ነገርት?  1. አዎ  2. አልነገረኝም
- ሐ) ችግር ቢያጋጥም ምን ማድረግ እንዳለበት ነገርት?  1. አዎ  2. አልነገረኝም
- መ) የተሰጠው የወሊድ መቆጣጠሪያ ኤች አይ ቪን እንደማይከላከል ገለጸልዎት (ኮንዶም ካልሆነ)  1. አዎ  2. አልገለጸልኝም

24. ለተሰጥዎት የወሊድ መቆጣጠሪያ በከፊሉት ክፍያ ደስተኛ ነዎት?

- 1. አዎ  2. አይደለሁም  3. አልከፈልኩም

25. የጤና ባለሙያው መኝ መመለስ እንዳለበት ነገርዎት?

- 1. አዎ  2. አልነገረኝም

26. ያልገባዎትን ጠይቀው ለመረዳት ይመኙ ነበር?

- 1. አዎ  2. አይመኙም

27. የተሰጥዎት መረጃ ፣

- 1. በጣም ትንሽ  2. በቂ  3. በጣም ብዙ  አላውቅም(99)

28. የማህፀን ምርመራ ተደረገልዎት?

- 1. አዎ  2. አልተደረገልኝም

29. አገልግሎቱን ያገኙት ሚስጥሮ ሊጠበቅ በሚችልበት ቦታ ነው?

- 1. አዎ  2. አይደለም  አላውቅም(99)

30. የጤና ባለሙያ የህክምና አገልግሎቱን ሲሰጥዎት ሌሎች ደንበኞች ይመለከትዎት ነበር?

- 1. አዎ  2. አይደለም  አላውቅም(99)

31. ከጤና ባለሙያ ጋር ያደረጉት ውይይት በሚስጥሮ ያያዘልኛል ብለው ያምናሉ?

- 1. አዎ  2. አላምንም  አላውቅም(99)

32. ወደ ጤና ድርጅት ሲመጡ የጤና ባለሙያው አቀባበል እንዴት ነበር?

- 1. በጣም ጥሩ  2. ጥሩ  3. ደካማ/የማያስደስት

33. ወደ ጤና ድርጅቱ ሲመጡ የሌሎች የጤና ባለሙያዎች አቀባበል እንዴት ነበር?

- 1. በጣም ጥሩ  2. ጥሩ
- 3. ደካማ/የማያስደስት/  ሌላ ባለሙያ አላጋጠመኝም(99)

34. የወሊድ መቆጣጠሪያ አገልግሎት እስከሚያገኙ ድረስ ምን ያህል ጠበቁ?

- 1] ከ15 ደቂቃ ያነሰ  2] 15-30 ደቂቃ  3] 31-45 ደቂቃ

4] 46-60 ደቂቃ     5] 61-90 ደቂቃ     6] 91-120 ደቂቃ  
 7] 120 ደቂቃ በላይ     አላውቅም(99)

35. የጠበቁት ሰዓት እንዴት ነበር?

1.አላስጠበቀኝም     2.አጭር ነበር     3.ረጅም ነበር     አላውቅም(99)

36. አገልግሎት የሰጥታቸው ባለሙያ ስለ ኤች አይ ቪ ነገርዎት?

1.አዎ     1.አልነገረኝም

37. የጤና ባለሙያው ከሚወስዱት የወሊድ መቆጣጠሪያ በተጨማሪ ኮንዶም...እንዲጠቀሙ መከርዎት (የሚጠቀሙት ኮንዶም ካልሆነ)

1.አዎ     2.አልጠየቀኝም

38. ስንት ልጆች አልዎት? \_\_\_\_\_

39. ተጨማሪ ልጅ እንዲኖረት ይፈልጋሉ? (አልፈልግም ከሆነ ወደ ጥያቄ 46 እለፉ)

1.አዎ     2.አልፈልግም     3. ወሳኝ ባለቤቱ ነው

4.አምላክ ያውቃል     አላውቅም(99)

40. ከምን ያህል ጊዜ በኋላ ሌላውኛውን ልጅን መውለድ ይፈልጋሉ?

1]ከ2 አመት ባነሰ ጊዜ     2]ከ2 ዓመት በኋላ     አላውቅም(99)

41. የጤና ባለሙያው ስለተጨማሪ ልጅ መውለድ አወያዮት?

1.አዎ     2.አይደለም     3.አላውቅም

**አመሰግናለሁ::**

**11.5 Annex 5. Map shows where the study area (Batu /Ziway) located**



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## **Declaration**

**I, the undersigned, declare that this is my original work, has never been presented in this or any other university and that all the source materials used for the thesis have been duly acknowledged.**

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