

**ADDIS ABABA UNIVERSITY  
SCHOOL OF GRADUATE STUDIES  
COLLEGE OF DEVELOPMENT STUDIES**



**ASSESSMENT OF QUALITY OF FAMILY PLANNING SERVICES IN  
AKAKI KALITY SUB CITY, ADDIS ABABA**

**BY BECKA TASEW**

**A Thesis Submitted to the School of Graduate Studies of Addis  
Ababa University in Partial Fulfillment of the Requirements for the  
Degree of Master of Science in Population Studies**

**February, 2017**

**Addis Ababa**

**ADDIS ABABA UNIVERSITY SCHOOL OF GRADUATE  
STUDIES COLLEGE OF DEVELOPMENT STUDIES  
CENTER FOR POPULATION STUDIES**

**ASSESSEMENT OF QUALITY OF FAMILY PLANNING  
SERVICES IN AKAKI KALITY SUB CITY, ADDIS ABABA**

**BY BECKA TASEW**

*Approved by the examining board*

*Dr. Chalachew Getahun*

*(Department Head)*

\_\_\_\_\_  
*Signature*

*Dr. Assefa Hailemariam*

*(Advisor)*

\_\_\_\_\_  
*Signature*

*Dr. Kassahun A.*

*(External examiner)*

\_\_\_\_\_  
*Signature*

*Tariku Dejene (MSC)*

*(Internal examiner)*

\_\_\_\_\_  
*Signature*

**February, 2017  
ADDIS ABABA**

## **Acknowledgement**

First and for most, I would like to express my deepest gratitude and appreciation to my advisor Dr. Assefa Hailemariam for his assistance in giving me constructive and appropriate guidance from the selection of the topic to the finalization of this study. His ever openness and readiness for assistance and guidance has greatly helped me to carry out this work successfully. Had it not been for his welcoming face, critical comments, and unreserved guidance, this thesis would have not been shaped in its present form. Next, I would like to extend my honest thanks to my brother Samson Tasew for financing the study and encouragement throughout the work. Your patience, understanding, and concern will always be remembered with warmth.

I would like to thank staffs of Akaki kality sub city health office who helped me facilitating the data collection process. My thanks go to all data collectors and respondents for their willingness to participate in the study.

Last but not least, my deepest thanks also refer to all my friends and classmates for their motivation and follow up all the way through the compilation of my study.

## Table of Contents

<i>Contents</i>	<i>Page</i>
Acknowledgement .....	i
Table of Contents .....	ii
List of Tables .....	v
List of Figures .....	v
Acronyms and Abbreviations .....	vii
Abstract .....	viii
CHAPTER ONE .....	1
1. INTRODUCTION .....	1
1.1. Background of the Study .....	1
1.2. Statement of the Problem .....	3
1.3. Objectives of the Study .....	6
1.3.1. General Objective .....	6
1.3.2. Specific Objectives .....	6
1.4. Research Hypotheses .....	6
1.5. Significance of the Study .....	6
1.6. Scope of the Study .....	-----
<b>Error! Bookmark not defined.</b>	
1.7. Definition of Terms/Concepts .....	7
CHAPTER TWO .....	9
2. LITRATURE REVIEW .....	9
2.1. Definition of Quality of Care .....	9
2.2. Measurement of Quality of Care .....	10
2.3. The Rational for Family Planning .....	11
2.3.1. Health Rationale .....	11
2.3.1.1. Preventing Pregnancy-related Health Risks in Women .....	11
2.3.1.2. Reducing infant mortality .....	12
2.3.1.3. Helping to prevent HIV/AIDS .....	12

2.3.2. Demographic rationale.....	12
2.3.2.1. Slowing Population Growth .....	12
2.3.2.2. Empowering people and enhancing education.....	13
2.3.3. Human Rights Rationale.....	13
2.4. The Effect of Quality of care on FP adoption and continuation.....	13
2.5. Analytical Framework of the Study.....	16
CHAPTER THREE .....	19
3. METHOD OF THE STUDY.....	19
3.1. Description of the Study Area.....	19
3.2. Study Design, Study population, Sample Size and Sampling Procedure .....	20
3.3. Data Collection Instrument.....	22
3.3.1. Quantitative .....	23
3.3.2. Qualitative.....	23
3.3.3. Study Variables.....	24
3.4. Data Processing and Analysis Plan.....	25
3.5. Pretest.....	26
3.6. Ethical Consideration.....	26
CHAPTER FOUR.....	27
4. RESULTS.....	27
4.1. Demographic and Socio-Economic Characteristics of the Respondents .....	27
4.2. Client Exit Interview.....	29
4.2.1. Assessment of knowledge among new & revisiting clients.....	29
4.2.2. View of clients on the waiting time of health service delivery points.....	30
4.3. The Quality Elements in the Family Planning services (Exit interview).....	31
4.3.1. Choice of Methods by family planning users .....	31
4.3.2. Information Given to the Clients .....	32
4.3.3. Client Provider Interaction.....	33
4.3.4. Technical Competence.....	35
4.3.5. Mechanism to Encourage Continuity.....	35
4.3.6. Appropriate Constellation of Services .....	35

4.4. Bivariate Analysis.....	37
4.5. Multivariate Analysis.....	38
4.6. Observation.....	40
4.6.1. Provider Competence.....	40
4.6.2. Functional capacity (logistics and supplies).....	42
4.6.2.1. Infrastructure.....	42
4.6.2.2. Logistics and supplies.....	43
4.6.2.3. Management & Supervision.....	44
4.6.2.4. Follow-up or Continuity Mechanisms.....	44
4.7. In-depth Interview.....	45
4.8. Mystery Client.....	46
CHAPTER FIVE.....	49
5. DISCUSSION.....	49
5.1. Structural Attributes (Input).....	49
5.2. Service Delivery (Process).....	52
5.3. Client Satisfaction (Outcome).....	56
CHAPTER SIX.....	57
6. CONCLUSIONS AND RECOMMENDATIONS.....	57
6.1. Conclusion.....	57
6.2. Recommendation.....	58
References.....	60
Anexes.....	66

## List of Tables

*Page*

Table 4.1 Percentage Distribution of Respondents by selected background characteristics in Akaki Kality March, 2015-- .....	28
Table 4.2. The waiting time of clients in 11 SDPS in Akaki Kality subcity, March, 2015-----	31
Table 4.3. Information given to new clients in 11 SDPs in Akaki Kality subcity March, 2015----	33
Table 4.4. Client provider interaction in 11 SDPs in Akaki Kality subcity March, 2015 .....	34
Table 4.5. Overall client satisfactions on quality of family planning services with set of 11 Yes/No questions as reported by women in 11 SDPs, in Akaki kality, March, 2015--	35
Table 4.6. Logistic Regression Results Variables in Relation to Client Satisfaction at 11 Service Delivery points, in Akaki Kality sub city, March, 2015-----	39
Table 4.7. Information given to clients as observed by mystery clients in 11 SDPs In 11 SDPS, in Akaki Kality subcity, March, 2015-----	48

<b>List of Figures</b>	<b>Page</b>
Figure 1 The Quality of The Service Experience—Its Origins and Impacts -----	18
Figure 2 Akaki Kality Subcity Woreda Map -----	19
Figure 3 The percentage distribution of clients’ knowledge on the side effects of implant in 11 SDPs in Akaki Kality subcity, March, 2015--- -----	29
Figure 4 The percentage distribution of Clients knowledge on the side effects of Pills in 11 SDPs, in Akaki Kality subcity, March, 2015-----	30
Figure 5 The percentage distribution of contraceptive methods by family planning users in 11 SDPs, in Akaki Kality subcity , March, 2015-----	32
Figure 6 Pie chart that shows the overall client satisfaction on quality of FP services in 11 SDPs in Akaki Kality Subcity, March, 2015-----	36
Figure 7 The percentage distribution of IEC materials used for new clients in Akaki Kality subcity, in 11 SDPs, March, 2015-----	41

<b><i>Annexes</i></b>	<b><i>Page</i></b>
Annex 1: English questionnaire for exit interview-----	66
Annex 2 Checklists for observation-----	75
Annex 3 Checklists for in-depth interview-----	80
Annex 4 Checklist for facility inventory-----	84
Annex 5 Checklists for mystery client-----	88
Annex 6 Amharic questionnaires for exit interview-----	92

## **Acronyms and Abbreviations**

AOR	Adjusted Odd Ratio
COR	Crude Odd Ratio
CPR	Contraceptive Prevalence Rate
CSA	Central Statistical Agency
EDHS	Ethiopian Demographic and Health Survey
EMDHS	Ethiopian Mini Demographic and Health Survey
FP	Family Planning
FGAE	Family planning Guidance and Association of Ethiopia
HIV/AIDS	Human Immune Virus /Acquired Immune Deficiency Syndrome
HSDP	Health Sector Development Plan
ICPD	International Conference on Population and Development
IPPF	International Planned Parenthood Federation
IUD	Intrauterine Device
MCH	Maternal and Child Health
MDG	Millennium Development Goal
NGO	Nongovernmental Organization
SDP	Service Delivery Point
STIs/STD	Sexually Transmitted Infections/Sexually Transmitted Disease
TFR	Total Fertility Rate
TGE	Transitional Government of Ethiopia
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization

## ***Abstract***

*Family planning programs have contributed greatly to fertility decline in developing countries, quality of family planning services have contributed in increasing contraceptive use and declining fertility rates .Good quality care in family planning services helps individuals and couples meet their reproductive health needs safely and effectively. A cross sectional study that employed exit interviews with clients, service provider interviews, observations of client-provider interactions, an assessment of the availability of the necessary resources and mystery client observation was conducted in eleven governmental, private and non-governmental service delivery points operating in Akaki-Kality sub city. The study included 415 women through a cross sectional study design to collect primary data. Qualitative and quantitative methods of data collection and analysis were employed. The necessary data were generated both from primary and secondary sources to answer the research questions. Of all the respondents, 76.9% of clients were satisfied with the overall quality of family planning services. The staff treated the clients respectfully in 65.5% of the cases and privacy was maintained for 70.4% of women. Information given about the method was sufficient for 65.3% of clients and 28.2% of clients had an opportunity to ask question. The waiting area was comfortable for 66.5% of women using family planning service and 86.5% of clients were satisfied with the cleanness of the clinic room. Logistic regression analysis of clients' satisfaction indicated constraints in delivering quality of FP services, which mostly accounts from information given to clients, treating the clients respectfully, maintaining privacy during consultation, cleanness of the clinic room and uncomfortable waiting area lacking seat that accommodate client load. Further, infection prevention procedures were not applied in the majority of the facility. Several aspects of the quality of services observed by this study need to be improved and measures should also be taken to improve the provision of family planning services through training, maintaining adequate resources and supportive supervision.*

# CHAPTER ONE

## INTRODUCTION

### 1.1. Background of the Study

The early family planning (FP) initiatives in the 1950s and 1960s were motivated by demographic concerns; the vanguard countries developed family planning programs in an effort to control rapid population growth (Bertrand, Magnani and Rutenberg, 1994).

Quality of care, a client-centered approach to providing high-quality health care as a basic human right, has emerged as a critical element of family planning and reproductive health programs. It has been promoted by local stakeholders, such as women's health and primary health care organizations, and affirmed at international conferences, such as the 1994 International Conference on Population and Development (ICPD) (Creel, Sass, and Yinger, 2002).

The growing interest in the quality of reproductive health services over the last decade has come from a concern with the high levels of maternal mortality and morbidity in developing countries. Ethiopia is one of the countries with the highest maternal mortality in Africa. The maternal mortality ratio was 676 maternal deaths per 100,000 live births (CSA and ICF international, 2012). Family planning plays an essential role in improving maternal health, which is one of the eight Millennium Development Goals (MDG<sub>5</sub>) world leaders have pledged to achieve by 2015. Family planning is a low-cost yet effective way to lower maternal mortality by reducing the number of high-risk births. Pregnancies that are too early, too close, too many, or too late pose adverse health consequences for the mother, child, and family (USAID, MOH, 2012). In Ethiopia, the probability of an adult woman dying from a maternal cause during her reproductive lifespan is about one in forty (WHO, 2010).

In Ethiopia there have been efforts in family planning service to increase contraceptive prevalence rate. Modern FP service in Ethiopia is pioneered by the Family Guidance Association of Ethiopia (FGAE), which was established in 1966 as Non-governmental, non profitable organization with the aim of providing family planning information, counseling and services to families who voluntarily expressed their need to space or limit birth (FGAE, 2000). The

Transitional Government of Ethiopia (TGE) adopted a population policy in 1993 with an objective of reducing the total fertility rate from 7.7 children per woman in 1990 to 4.0 children per woman in 2015, increase the prevalence of contraceptives use from 4 percent in 1990 to 44 percent in 2015 and reduce maternal, infant and child morbidity and mortality rates by expanding family planning programs and services (TGE, 1993). Although the percentage of women using contraceptive has increased from 6% in 2000 to 29% in 2011 and then to 42% in 2014 (CSA and ORC Macro, 2006 & CSA and ICF international, 2012), the performance was not enough. On the other hand in 1996, the Ministry of Health released ‘Guidelines for FP services in Ethiopia’ to guide stakeholders as well as expand and ensure quality FP services, and the revised guidelines which was released in 2011 includes new outlets for FP services in addition to the pre-existing facility based and outreach FP services (MOH, 2011). Moreover the first of the four major areas in strategic objective I of the health sector development plan (HSDP-IV) that covers the period 2010/11-2014/15 is to improve the health of mothers, neonates, children, adolescent and youth. In this regard, reducing maternal mortality ratio to 267/100,000 and increasing skilled birth attendance to 60% and the CPR to 65% by 2015 are targets set by HSDP IV. One strategy to achieve MDG5 and the objectives of HSDP IV is expanding quality FP services (MOH, 2010). From the above data, we can consider that inconsistencies were observed in setting CPR objectives to be achieved in 2015(44% in 1993 and 65% in 2011). The reason could be over the last 15 years more attention has been given by the government. For instance, increasing the number of HSDPs, improving the quality of existing HSDPs through training and management etc (USAID, FMOH, 2012).

Family planning programs have contributed greatly to fertility decline in developing countries. Both availability and quality of family planning services is believed to increase contraceptive prevalence rate. There is general agreement that quality of family planning and reproductive health services positively affects contraceptive use and behavior of the clients and those clients deserve to receive safe and high quality of service with respect and dignity (Rathavut, Livia and Vinod, 2006). Good quality cares in family planning services helps individuals and couples meet their reproductive health needs safely and effectively. Poorly delivered family planning services can lead to incorrect, inconsistent or discontinued contraceptive use and cause unwanted pregnancies infections, injuries and even death (Bruce, 1980). Review of existing literatures suggest that the quality of service provided are an important determinants of acceptance and

continuation rates and therefore a major contributor to increase in contraceptive prevalence (Jain, 1989).

Assessment of quality of service delivery in health facilities is receiving growing recognition as a strategy for monitoring and evaluation of primary health care program in developing countries including family planning.

## **1.2. Statement of the Problem**

An estimated 222 million women in developing countries would like to delay or stop childbearing but are not using any method of contraception. One of the reasons for this includes poor quality of available services (WHO, 2013). The unmet need for family planning services in Ethiopia is believed to be high while the already available services do not appear to be optimally used by potential clients (Mesganaw, 2005). Numerous studies have examined the effects of family planning quality on the uptake and continuation of family planning methods (Bruce, 1980 and Jain, 1989). According to the 2011 EDHS the 12-month contraceptive discontinuation rate for all methods is 37 percent. Among the major methods, the highest discontinuation rate is for the pill (70 percent), followed by the male condom (62 percent). In contrast, implants have a discontinuation rate of just 5 percent.

According to the World Health Organization, family planning saves lives of women, children, and communities and improves the quality of life for all by reducing fertility (WHO, 1995). In sub-Saharan Africa the rate of population growth is one of the highest in the world (2.8%) as compared to the rest of the world (USAID/HPI, 2007). Ethiopia is the second largest country in Africa (next to Nigeria) with an estimated population of nearly 87,952,000 and a growth rate of 2.6 percent per year (CSA, 2008).

Every day, nearly 800 women die from avertable causes related to pregnancy and child birth of which 99% take place in developing countries. More than half of these deaths occur in sub-Saharan Africa (WHO, 2012). According to UN and Lancet latest estimates, in Ethiopia, the proportion of mothers dying per 100,000 live births was 420 and 497 respectively in 2013 (FMOH, 2015). Even though a reduction was observed in maternal mortality compared with the 2011 EDHS which was 676 per 100,000 live births, it was not enough. Therefore, the Federal Ministry of Health of Ethiopia has planned to reduce the maternal mortality from 420/100,000

live birth to 177-199/ 100,000 live births by 2020. Furthermore, the Federal Ministry of Health of Ethiopia has also planned to reduce infant mortality from 46.4 to 16.7-19.33 per 1,000 live births and under five mortality rates from 68 to 26-29.6 per 1,000 live births by 2020 (FMOH, 2015 and CSA and ICF International, 2012).

The number of new acceptors, continuing users, the couple years of protection conferred to users, the contraceptive prevalence rate, proportion of woman using long term family planning methods and total fertility rate are the most common measurements of effective family planning programs (Bruce, 1990).

Contraceptive use has increased in many parts of the world, especially in Asia and Latin America, but continues to be low in sub-Saharan Africa. Globally, use of modern contraception has risen slightly, from 54% in 1990 to 57% in 2012. Regionally, the proportion of women aged 15–49 reporting use of a modern contraceptive method has risen minimally or plateaued between 2008 and 2012. In Africa it went from 23% to 24%, in Asia it has remained at 62%, and in Latin America and the Caribbean it rose slightly from 64% to 67%. There is with significant variation among countries in these regions (WHO, 2013). According to the EDHS, in Ethiopia, use of modern methods among currently married women has increased from 27 percent in 2011 to 40 percent in 2014. This means that use of modern methods in Ethiopia is very low as compared to the global average but has no significant difference to the African average. Furthermore, the performance of Addis Ababa (57%), which has the highest use of modern contraceptive method, is low as compared to the national target (65%) set by the MOH under the HSDP IV which ends by 2015. This indicates that the country is off-track to meet this goal.

In Ethiopia few studies were conducted on quality of family planning services which shows that client dissatisfaction were very high on maintenance of privacy and level of out patient satisfaction (Mesganahu, 2005, Loha, Asefa, Jira and Tessema, 2003, Tseganeh, 2005). A study conducted on Jimma on outpatient client satisfaction show that overall 57.1% of clients believed that services they received was good and very good (40%).

In Addis Ababa few studies were conducted on quality of care in family planning, which were conducted twenty years ago. While one dealt with the clients' perspective which was limited to an NGO clinic only, the other one, which was conducted by Yetnayet Asfaw, included several

health institutions and she indicated that shortage of logistics and supplies, poor clients' record, inadequate supervision, poor counseling service and long waiting time were constraints to satisfy clients. Finally she recommended efforts that should be made by the government to address the above problems (Yetnayet, 1995 and Korra, 1997).

Over the last 15 years, more attention has been given by the government of Ethiopia to improve the quality of family planning services through a 20-year Health Sector Development Program (HSDP), such as: Improvement in infrastructure, specially health centers and health posts, improvement in health system quality, especially logistics and supervision, improving the quality of existing health centers and hospitals through training and management, inclusion of health partners and NGOs in the program and bringing services to the doorstep in the rural areas through the health extension workers (USAID, FMOH, 2012).

Yet no recent information on the quality of the existing FP services is available in Akaki Kality sub city because the two researches were conducted almost twenty years back and since then a number of strategies have been implemented by the FMOH to improve the quality of FP services including those recommended by the researchers. Moreover, the study, which was conducted by Korra in 1997, was limited to NGO clinics only; as a result, it may fail to represent the quality of FP services of governmental and private for profit health facilities. On the other hand the study conducted by Yetnayet had also a methodological limitation, which means providers might also show the best behavior responses (stage performance) when they were being observed by data collector during client-provider interaction. Furthermore according to the data projected from the 2007 census Akaki Kality has the highest fertility rate, which might be caused by poor provision of FP services. Against this background and in response to the above concern that the objective of the study was drawn. The study, therefore, attempted to bridge the knowledge gap by analysing data that were collected through different methods such as clients' exit interview, providers' in-depth interview, observation, facility audit and mystery client observation to assess the current status of quality FP services in Akaki Kality sub city, which involved governmental, private and NGO health facilities.

### **1.3. Objectives of the Study**

#### **1.3.1. General Objective**

- To assess the status of quality of family planning services in Akaki-kality sub city in Addis Ababa.

#### **1.3.2. Specific Objectives**

- To assess the magnitude of client satisfaction with family planning service.
- To assess the knowledge and skills of FP service providers on contraceptive methods.
- To assess client provider interaction in family planning services provision.
- To assess the availability, adequacy of logistics and supplies for FP provision.

### **1.4. Research Hypotheses**

Generally, when family planning programs provide higher levels of quality and client-centered services.

- The more likely clients are to be satisfied.

Offering a range of contraceptive method mix

- Provides more choices for clients.
- Attracts more clients.

Better counseling and information giving improve client satisfaction by

- Creating awareness.
- Increasing knowledge.
- Building acceptance.

### **1.5. Significance of the Study**

Now a day, the issue of quality family planning services is an important agenda in developing countries including Ethiopia. In Ethiopia few studies were conducted on quality of family planning services which shows that client dissatisfaction is very high on maintenance of privacy and level of outpatient satisfaction. (Yetnayet, 1995, Mesganaw, 2005, Loha, Asefa, Jira and Tessema, 2003, Tseganeh, 2005). Understanding the status of quality of family planning services is crucial and a major input for monitoring, evaluation and implementation of reproductive health and family planning programs. Therefore this study assessed quality of family planning services

and found out factors that lead to poor quality of services in Akaki-kality sub city, in Addis Ababa using the Judith Bruce frame work developed in 1990.

This study is important because it attempted to assess the overall level of client satisfaction with the quality of care, the availability, adequacy of logistics and supplies and client provider interaction during family planning service provision. It also attempted to find out certain factors that slow down clients' use of services in order to make recommendations to governmental and nongovernmental organizations to help them design prioritized possible intervention or set appropriate strategies to improve clients' satisfaction, continue and sustain use of services and improve the health outcome of women in service delivery points. This study can also be used as a reference by researchers in future studies.

### **1.6. Scope of the Study**

- ❖ Since the study is limited to the urban woredas where health facilities are available it may lack to represent the quality of family planning services of Akaki kality sub city.
- ❖ The study will not include all urban health facilities because of limited time and finance that may challenge the quality of the data.
- ❖ Only female contraceptive users were selected, so it was not comprehensive enough to represent all males and females who are contraceptive users.
- ❖ The multidimensionality of quality measurements.

### **1.7. Definition of Terms/Concepts**

**Quality:** is a multidimensional concept, but in this study, it was measured in terms of clients satisfaction, providers' perspective, observation of client provider interaction and availability of facilities, supplies and instruments for FP service provision.

**Adequate/sufficient/privacy;** privacy which ensure visual and auditory privacy.

**Client provider relationship;** refers to the level of trust, respect and information exchanged between the service provider and their clients.

**Technical competence:** refers to skill and experience of provider. Clients can judge the technical competence of the providers.

**Logistics:** Family planning equipment, supplies and physical set ups like storage facilities for use by service delivery points.

**Information given to clients:** refers to adequate, accurate and complete information given to new or continuing clients about the methods available, their use, the advantages and disadvantage and contraindications of the method decided by the client.

**Permanent resident;** clients who lived in catchment's area and not coming as referral.

**Comfortable waiting area:** an area protected from both rain and sun with enough seats to accommodate the average daily client load.

**Informed choice:** refers to a situation when a client freely makes a thought-out decision or choice of contraceptive based on accurate and useful information provided by a provider.

**Waiting time-**refers to the time gap between the client's arrival at the service delivery point and the time the client received FP service. Waiting time is acceptable if is less than 30 minute and not acceptable if it is greater than 30 minute.

**Counseling:** refers to a type of client provider interaction or dialogue in which providers use their communication skill and technical knowledge to help clients make or confirm decisions, such as choosing contraceptive method.

**Method Availability-**refers to the availability of more than one family planning method in a family planning service delivery clinic or health facility.

**New clients-** women who accept for the first time in their lives any contraceptive method.

**Repeat clients (Revisiting) -** women who received family planning service more than one time.

**Client Satisfaction-** is clients' opinion of care received from FP services/staff is acknowledged as an outcome indicator of quality of care/service. In this study factor score of the satisfaction scale was used to measure the level of client satisfaction (satisfaction score). Of 11 quality measurement items, those clients who scored  $\geq 6$  were designated as satisfied and  $\leq 5$  were designated as dissatisfied.

## **CHAPTER TWO**

### **LITERATURE REVIEW**

#### **2.1. Definition of Quality of Health Care**

Historically, quality has been defined at a clinical level, and involves offering technically competent, effective, safe care that contributes to the client's well-being. But quality of care is a multidimensional issue that may be defined and measured differently, according to stakeholders' priorities (Creel, Sass and Yinger, 2002).

The Bruce-Jain framework, which was developed in 1990, is often considered the central paradigm for quality in international family planning. Judith Bruce and Anrudh Jain have defined quality as "the way individuals and clients are treated by the system providing services" (Bruce 1990; Jain 1989). The framework identifies six elements, which apply mainly to clinical services, relevant to improving the quality of care in family planning programs: choice of contraceptive methods, information given to patients, technical competence, interpersonal relationships, continuity and follow-up, and the appropriate constellation of services.

The world health organization defines quality as a process for making strategic choices in health systems. It suggests that a health system should seek to make improvements in six areas or dimensions of quality and these dimensions require that health care be: effective, efficient, acceptable (*patient-centered*), accessible, equitable and safe which minimizes risks and harm to service users (WHO, 2006).

The Client and Provider Bill of Rights, created by the International Planned Parenthood Foundation (IPPF), outlines 10 rights of family planning clients, and extends the definition of a client to everyone in the community who needs services, not merely those who approach the system. Thus the rights of the clients' have been defined as follows: Right to information, access, choice, safety, privacy, confidentiality, dignity, comfort, continuity and opinion (Rama, Lacuesta, Pangolibay and Jones, 2003).

The rights frame work recognizes that the client centered service should include the perspective of the provider who is in direct contact with the clients. The IPPF's perspective of service quality recognizes the importance of providers in service provision and thus defines their involvement in

the context of 10 needs. These are defined as the need for training, for information, infrastructure, supplies, guidance, backup, respect, encouragement, feedback and self expression (Rama, Lacuesta, Pangolibay and Jones, 2003).

The Institute of Medicine defines quality as “the extent to which health services for populations increased the likelihood of desired health outcomes and are consistent with current professional knowledge (Guatemala Field Study, 2000).

The World Health Organization definition of quality encompasses the perspective of all these groups “Quality of health care consists of the proper performance (according to standards) of intervention that are known to be safe, that are affordable to the society in question and that have the ability to produce an impact on mortality, morbidity, disability and malnutrition. International Conference on Population and Development Program of Action states that family planning programs must make significant efforts to improve quality of care. It has also defined other dimensions of quality of care like access to information, convenience, safe and affordable services, with continuous supply, ensuring privacy and confidentiality in all health related matters. The quality of service also talks about appropriate follow up with effective referral services” (WHO, 1995).

“Quality” in terms of reproductive health care is currently defined in a variety of ways. A consensus exists that good quality requires the presence of trained personnel in well-equipped clinics where clients are treated courteously and provided with a variety of appropriate services. The term, therefore, refers both to the readiness or level of preparedness of facilities to offer services and the manner in which clients are cared for (Saumya and Raji, 2003).

## **2.2. Measurement of Quality of Care**

The definition and measurement of quality of care in family planning services primarily focuses on the work of Judith Bruce. The six elements of her frame work depend on the Donabedian’s three dimensions of quality such as structure, process and outcome which are related to each other. Because of this important link the description of the approaches to the definition and measurement of quality in family planning program is preceded by an outline of the Donabedian frame work (Bruce, 1990).

The Donabedian frame work, which is based on the three dimensions of quality; structure, process and outcome is defined as follows (as cited in Raeda , Salah, Laila , Salama and Firas, 1998).

*The Concept of ‘Structure’:* was considered to encompass the stable features of the providers of reproductive care, the tools and resources at their disposal, and the physical and organizational settings in which they work. Thus, structure includes the human, physical and financial resources that are used to provide reproductive health.

*The Concept of ‘Process’:* is defined as the set of activities that take place between the provider and woman. It refers to the actual transaction in which the provider of care makes use of the available structural elements, described above, to manage the technical and personal aspects of health.

*The Concept of ‘Outcome’:* includes two elements: the direct impact of treatment on the current or future health of a woman or her newborn, and the indirect impact on her satisfaction with the services offered and her health-seeking behavior. Even though the three dimensions of quality are related to each other, in this study, more emphasis was given to the structural and process measures of quality.

### **2.3.The Rational for Family Planning**

Promotion of family planning and ensuring access to preferred contraceptive methods for women and couples is essential to securing the well-being and autonomy of women, while supporting the health and development of communities.

#### **2.3.1. Health Rationale**

##### **2.3.1.1.Preventing Pregnancy-related Health Risks in Women**

A woman’s ability to choose if and when to become pregnant has a direct impact on her health and well-being. Family planning allows spacing of pregnancies and can delay pregnancies in young women at increased risk of health problems and death from early childbearing, and can prevent pregnancies among older women who also face increased risks. Family planning enables women who wish to limit the size of their families to do so. Evidence suggests that women who have more than four children are at increased risk of maternal mortality. By reducing rates of

unintended pregnancies, family planning also reduces the need for unsafe abortion (USAID, MOH, 2012; WHO, 2013; Feleke and Samuel, 2008).

### **2.3.1.2. Reducing infant mortality**

Family planning can prevent closely spaced and ill-timed pregnancies and births, which contribute to some of the world's highest infant mortality rates. Infants of mothers who die as a result of giving birth also have a greater risk of death and poor health (Singh et al, 2003, WHO, 2013 and Feleke & Samuel, 2008).

### **2.3.1.3. Helping to prevent HIV/AIDS**

Family planning reduces the risk of unintended pregnancies among women living with HIV, resulting in fewer infected babies and orphans. In addition, male and female condoms provide dual protection against unintended pregnancies and against STIs including HIV (Singh et al, 2003 and WHO, 2013).

## **2.3.2. Demographic rationale**

### **2.3.2.1. Slowing Population Growth**

Family planning is key to slowing unsustainable population growth and the resulting negative impacts on the economy, environment, and national and regional development efforts. High-quality voluntary family planning programs significantly reduce fertility, even in poor countries. A study conducted in poor countries by Andrudh Jain and John Ross examined Demographic and Health Survey data from 40 different countries to determine associations among the strength of family program effort, socio economic conditions and fertility. The study indicated that “For any given social setting, the average total fertility rate declines as the strength of the family planning program improves” (Jain and Ross, 2012).

On the other hand, voluntary family planning programs are also powerful tools to boost economies and reduce poverty. A study conducted by Bongaarts and Steven examined the effects of family planning on poverty. First, by reducing the birth rate, family planning programs can create a “demographic dividend” that spurs economic growth for a few decades by increasing the size of the labor force relative to both young and old dependents, and by making it possible for people to save more money. About a third of the rapid economic growth rates experienced by

East Asian tiger economies is the result of this dividend. Second, slower population growth allows families and communities to invest more in providing quality education and health care and to improve infrastructure. Children who are healthy and educated are primed to become productive adults who can help to fuel the economy (Bongaarts and Steven, 2011).

### **2.3.2.2. Empowering people and enhancing education**

Family planning enables people to make informed choices about their sexual and reproductive health. Family planning represents an opportunity for women for enhanced education and participation in public life, including paid employment in non-family organizations. Additionally, having smaller families allows parents to invest more in each child. Children with fewer siblings tend to stay in school longer than those with many siblings (Bongaarts and Steven, 2011 & WHO, 2013).

### **2.3.3. Human Rights Rationale**

This rationale became preeminent in the 1990s, in part because of the excesses reactions to the demographic rationale. It rests on the belief that individuals and couples have a fundamental right to control reproductive decisions, including family size and the timing of births. This rationale found its strongest articulation at the ICPD, held in Cairo, in 1994 (Feleke & Samuel, 2008; Creel, Sass, and Yinger, 2002)

## **2.4. The Effect of Quality of care on FP adoption and continuation**

Both availability and quality of family planning services are believed to have contributed to increasing contraceptive use and declining fertility rates in developing countries. There is general agreement that the quality of family planning and reproductive health services positively affects contraceptive use and behavior of the clients and those clients deserve to receive safe and high quality services with respect and dignity (Rathavuth, livia and vinod, 2006).

A longitudinal study of Bangladesh women demonstrated that those who perceived that they have received good quality of care from field workers were significantly more likely to adopt a contraceptive method than were those who did not (Koenig et al, 1997).

In Tanzania community perception of the quality of the available FP services were measured by interviewing a number of key informants in each community. The resulting analysis revealed that community perception of quality has direct effect on contraceptive use after controlling the individual level factors. The level of contraceptive use among women was lower where quality was perceived to be poor. Of the factors measured at the community level only quality had a significant effect on contraceptive use (Mroz et al, 1999).

Client satisfaction is integral component of health services. The effectiveness of health care is determined to some degree by consumer satisfaction with services provided. A satisfied patient is most likely to comply with medical treatment prescribed, provider and continue using medical services (Tetterseil, 1993). On the other hand, dissatisfied clients are more likely to share their negative experiences with others and are less likely to return or continue use of family planning services (Williams et al, 2000).

The most powerful predictor for client satisfaction with quality services was provider behavior, especially respect and politeness, for patients, provider behavior was much more important than the technical competence of the provider (Mendoza, Helga and Ahmed, 2001). Low patient satisfaction is associated with lower trust in care givers and greater chance of a change of health providers, resulting in less continuity of care (Liu, So and Quan, 2007). Deficiencies in infrastructure, interpersonal relations, privacy and information to clients are warning sign in the mechanism to continuity (De Silva and Fonseka, 2008).

A study conducted in the Gambia where 51% of those who felt they were not properly counseled discontinued use, compared with 14% of those who reported being well counseled. Similar findings are reported for China that acceptors of the injectables contraceptive Depo-Provera in four family planning clinics who received more information were significantly more likely to continue using the method than were those who received little information. The study concluded that women who receive detailed counseling concerning side effects are almost four times more likely to continue with the method than those who do not (Lei et al, 1996).

Receiving one's preferred method also seems to have effects similar to those resulting from being better informed. A follow up study of FP acceptors in Indonesia reported that women who had received their preferred method were significantly more likely than were those who had not

to be using a contraceptive a year later. The rate of discontinuation was 72 percent among those who had not received their chosen method, compared with 9% among those who had. The highest rate of discontinuation occurred when the choice of method was denied and both partners disagreed on method choice and the lowest rate of discontinuation occurred when method choice is granted and the spouses agreed about the method (Pariani et al, 1991). Therefore the evidence has identified that some aspects of the care giving process such as provision of clients' choice method, offering the client adequate information, and treating her or him courteously is significant factors in contraceptives.

Client satisfaction is key to clients' decisions to use and to continue using services and is essential to long- term sustainability. Ultimately, client-focused services that meet peoples' needs and provide them with satisfying experiences should help clients achieve their reproductive intentions (Williams, Schutt-Aine & Cuca, 2004).

A study conducted in Kenya regarding quality of family planning services shows that 40% of the respondents were uncertain about quality of family planning services provided, 41% agreed that quality was good while 19% agreed that quality was not good. This finding reveals that the cost of family planning is an important determinant of the use of family planning services (Tom, Nelson, Wawire, Okech, 2011).

In Ethiopia few studies were conducted on quality of family planning services which shows that client dissatisfaction were very high on maintenance of privacy and level of client satisfaction (Mesganahu, 2005, Loha, Asefa, Jira and Tessema, 2003, Tseganeh, 2005). A study conducted on Jimma on outpatient client satisfaction show that overall 57.1% of clients believed that services they received was good and very good (40%).

Other study conducted on quality of family planning service in the health facilities of east shoa zone, Oromia regional state indicated that clients in this study were found to be (very) satisfied by the quality of the FP service they received (86-93%). However, they indicated that providers didn't discuss with them on their fertility desire (76.9%), FP methods (56.3%) and the side-effect of the specific FP they took (67.7%). Also, significant proportion of clients didn't understand the information provided by the FP service providers (27.9%) (Getnet et al, 2008).

Training, education and skill enhancement is important to health care provider to insure client to adhere to services, the communication skills training program is an effective intervention to improve communication knowledge and skills of health workers and may improve the satisfaction rate of clients (Ahmadian et al, 2003). Thus the above literatures indicated that the higher levels of quality-particularly indicators that measure clients' perception of client-provider interactions-will yield higher levels of client satisfaction. In turn, higher rates of client satisfaction have been shown to yield higher family planning adoption and continuation rates.

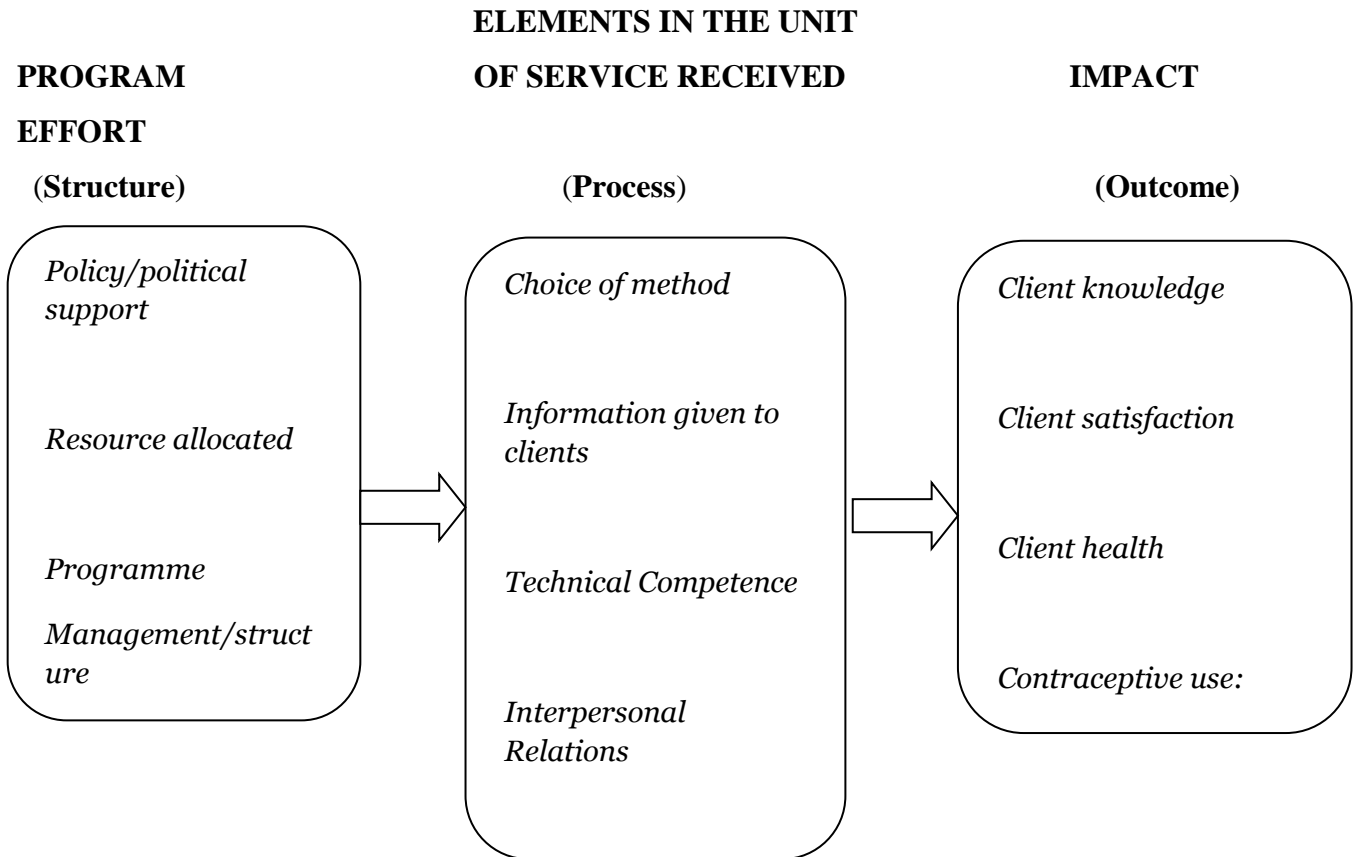
## **2.5. Analytical Frame Work of the Study**

The Bruce Jain frame work, developed in 1990, will be used in this study which is the central paradigm for measuring quality in international family planning program. The frame work emphasizes the importance of the client's perspectives and defines quality of care in terms of six fundamental elements. These are;

1. ***Choice of methods***: refers both to the number of contraceptive methods offered on a reliable basis and their intrinsic variability. Which methods are offered to serve significant subgroups as defined by age, gender, contraceptive intention, lactation status, health profile, and where cost of method is a factor -income groups? To what degree will these methods meet current or emerging needs (for example, adolescents)? Are there satisfactory choices for those men and women who wish to space, those who wish to limit, and those who cannot tolerate hormonal contraceptives, and so forth?
2. ***Information given to clients***: refers to the information imparted during service contact that enables clients to choose and employ contraception with satisfaction and technical competence. It includes: information about the range of methods available, their scientifically documented contraindications, advantages, and disadvantages; screening out unsafe choices for the specific client and providing details on how to use the method *selected*, its possible impacts on sexual practice, and its potential side effects; explicit information about what clients can expect from service providers regarding sustained advice, support, supply and referral to other methods and related services, if needed

3. **Technical competence:** involves factors such as the competence of the clinical technique of providers, the observance of protocols, and meticulous procedures required to provide clinical methods such as IUDs, implants and sterilization
4. **Inter personal relations:** are the personal dimensions of services. Relations between providers and clients are strongly influenced by a programme's mission and ideology, management style, resource allocation, (for example, patient flow in clinical settings) the ratio of workers to clients, and supervisory structure.
5. **Mechanism to encourage continuity:** indicate a programme's concern and ability to promote continuity of contraceptive use, whether well-informed users manage continuity on their own or the programme has formal mechanisms to ensure it. For example, the use of media, or specific follow-up mechanisms, such as forward appointments or home visits.
6. **Appropriate constellation of services:** refers to situating family planning services so that they are convenient and acceptable to clients, responding to their natural health concepts, meeting pressing pre-existing health needs. Services can be appropriately delivered through a vertical infrastructure, or in the context of MCH initiatives, postpartum services, comprehensive reproductive health services, employee health programmes, or others

This framework is meant to provide an ordered point of departure from which to develop a description of the service unit and defines its quality. Attention is center on the experience of those who have gained access to service. The client usually does not see the policy, resource allocation decision and management tasks that precedes the delivery of service are not directly experienced but their outcome the service giving. Figure 1 is a graphical display of the framework and its hypothesized relationship between program efforts, quality of service experiences and its impacts (Bruce, 1990).



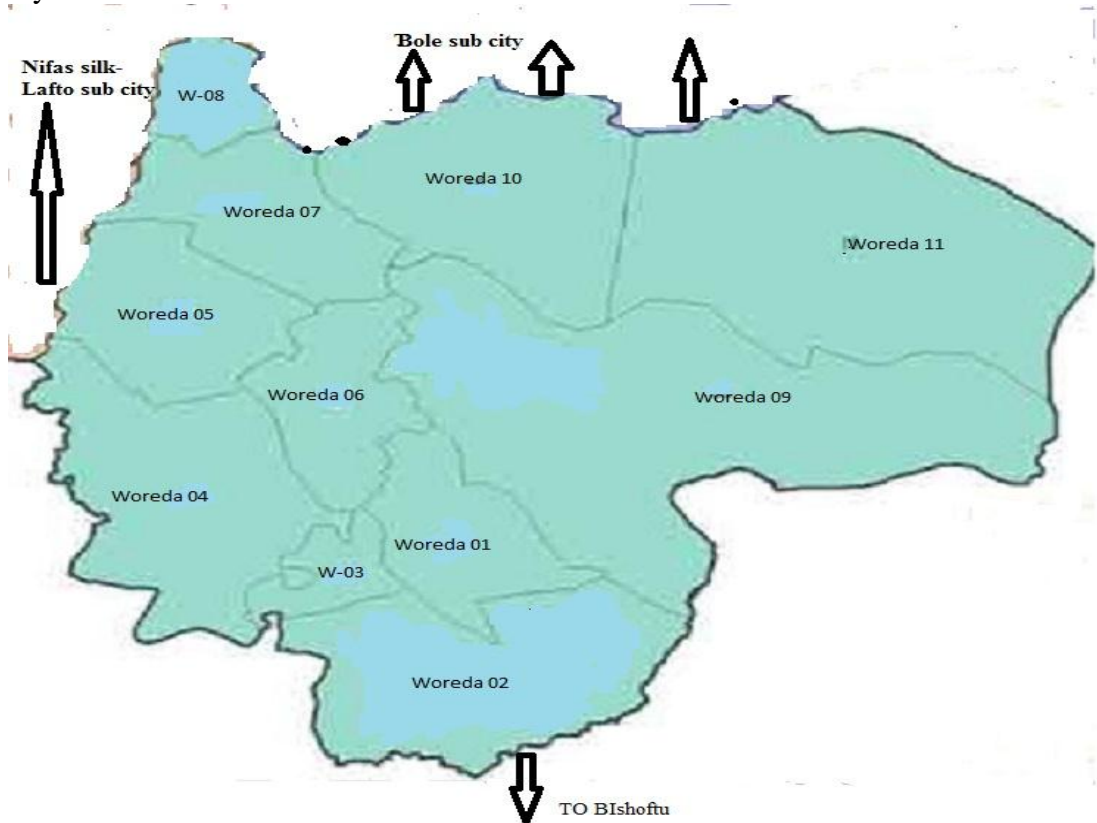
**Figure.1. The Quality of The Service Experience—Its Origins and Impacts**

**Source: Judith Bruce, 1990**

## CHAPTER THREE METHOD OF THE STUDY

### 3.1. Description of the Study Area

The Study was conducted in Akaki Kality sub city in Addis Ababa. Akaki Kality is one of the ten sub cities of Addis Ababa located in the southern part of the city. The sub city has 11 woredas (8 urban and 3 rural) and most of the woredas are found at the periphery of the city. According to the 2007 Population and Housing Census of Ethiopia the total population of Akaki Kality sub city is 211,390 of which 102,959 are male inhabitants and 108,421 are female inhabitants. Currently the total fertility rate of the city is about 1.8 children per woman (EDHS 2011), which is below replacement level. Though the Total Fertility level is very low at city level, it is not spatially equally distributed to all the 10 Sub Cities. According to the data projected from 2007 census Akaki Kality, has the highest fertility level of 2.9 (AA. BoFED, 2013/14). Therefore, it is desirable to assess the quality of family planning services in Akaki Kality sub city.



**Total population;** 211,390      **Male;** 102,959      **Female;** 108,421      **TFR;** 2.9

**Figure 2: Akaki Kality Subcity Woreda Map**

## **3.2. Study Design, Study population, Sample Size and Sampling Procedure**

### **Study Design**

Facility based cross-sectional study design with both quantitative and qualitative research approach was employed to assess the quality of family planning services in Akaki kality sub city, Addis Ababa.

### **Study population**

The study populations were women in the reproductive age group 15-49 years who visited the HSDPs for FP services during data collection period and all family planning service providers to the corresponding service delivery points.

### **Inclusion criteria**

Client:

- Women in the reproductive age group 15-49
- Women, who are willing, mentally and physically capable of being interviewed.

Provider:

- Health professionals that provide family planning services.
- Worked in the institution for at least one month.
- Volunteer to participate in the study.

### **Exclusion Criteria**

**Client**

- Refuse to participate in the study
- Clients with speech or hearing impaired and critically ill
- Clients who received family planning services direct from drug retail

## Provider:

- Who worked in the institution for less than one month
- Who is not involved in family planning care
- Unwilling to participate

## Sample Size Determination

Sample size will be determined using the formula for single population proportion based on the following assumptions (Julie, 2004).

$$n = \frac{p(1-p)(z_{\alpha/2})^2}{e^2}$$

Where: n= is the size of the sample

Z= is the standard normal value corresponding to the desired level of confidence

e=error of precision

P= is the estimated proportion of clients satisfaction with the availability of skilled personnel and contraceptive method since client satisfaction on FP service is not known for the sub city, P value of 50% will be taken.

## Assumptions

- i) In the absence of the previous prevalence data on the population under study, and to obtain the maximum sample size, p is assumed to be= 0.5 or 50%
- ii) Margin of error e= 5% is accepted
- iii) A confidence interval of 95% is assumed ( $z_{\alpha/2}=1.96$ ).

$$n = \frac{(1.96)^2 0.5(1-0.5)}{(0.05)^2} = 384$$

For non-response, 10% of contingency added to the sample size= 38, then, the final sample size = 422.

## **Sampling methods and Procedure**

In Akaki-kality sub-city there are one Governmental hospital and one private for profit hospital, two nongovernmental medium clinics, 30 private for profit clinics (medium 26 and higher 4) and 6 government health centers which provides family planning services, in total 39 health facility. The study involved governmental, private and nongovernmental health facilities. Since the study involved facility based data collection, from the total of eleven woredas, three from urban and eight from rural, only the urban woredas except woreda two with no family planning service delivery point were covered by the study for sampling, because the rural woredas namely woreda nine, woreda ten and woreda eleven did not provide facility based family planning services.

For the quantitative data, from a total of seven Woredas that provides facility based family planning services, for logistical and cost arrangements, five Woredas were selected randomly by using lottery method to collect data from health facilities. Then for each woreda all governmental service delivery points and one private/non-governmental SDPs were selected randomly.

The allocated sample size for each health facility was obtained using probability proportional to the size of client flow found in each SDP and then clients were interviewed continuously in the facility after they have received the service until the required number was interviewed. From the five sampled Woredas, a total of 415 eligible respondents were interviewed for an exit interview.

For the qualitative design an open ended in depth interview was made for 14 service providers who were present during data collection. Moreover, observation of client-provider interaction, facility audit and mystery client observation by the data collectors were also made in order to triangulate responses that were obtained by exit interview. The data collection was carried out by trained people of different age group whose educational status ranges from grade 12 complete to degree holders in accordance with each data collection instrument.

### **3.3. Data Collection Instrument**

To provide a broad and detailed picture of the availability of quality FP services, the study consist of five data collection components. The data collection instruments included elements of quality in accordance with Judith Bruce frame work of quality of care that includes: programme efforts (resource allocation and management), the service giving elements and its impact

(output). Anonymous close ended questionnaires were interviewed by data collectors which consisted of four different sections: client exit interview, observation of client provider interaction, facility audit and mystery client observation. In depth interview was also made for service providers.

### **3.3.1. Quantitative part**

#### **1. Interview**

A close ended questionnaire which was developed based on Judith Bruce analytical framework was prepared for 415 new and repeat clients exit interview who received family planning services to determine the socio demographic variables, clients' satisfaction, availabilities of methods, knowledge of clients on contraceptive methods, technical competence etc.

### **3.3.2. Qualitative**

#### **2. Observation**

Structured checklists were used to observe 100 client-provider interactions while the service was being provided at service delivery points. For this purpose data collectors were provided with checklists to mark yes/no answers and other activities that reflect the quality of family planning services to observe individual counseling and clinical examination.

#### **3. The Facility Inventory**

Facility audit was also made on the presence and functionality of the different logistics and supplies at 11 service delivery points. The focus was to assess the functional ability of facilities to provide services of acceptable standards.

#### **4. In depth interview**

An open ended in depth interview was also made for fourteen family planning service providers by the principal investigator in order to determine their training, knowledge and skills about contraceptive methods and procedures.

#### **5. Mystery Client**

For mystery client observation, six simulated clients were recruited. For each service delivery points, six mystery clients were recruited and briefings on selected topics of interest were given and information on points of interest was collected shortly after their observation. The six mystery clients were supposed to visit the SDPs for seeking information on services to space and for limiting birth. Simulated clients were categorized in to three different age groups. Below is a description of the three profiles of simulated clients.

**Group 1** was a female client in her early twenties (20-22), unmarried and with no children. The client has recently entered into a steady sexual relationship. The two girls who were college students played the role of the mystery client.

**Group 2** clients in the age bracket 28 to 30 years and was seeking contraceptives for the first time at the clinic. She had an 8 month old baby and she was not breastfeeding. The client wanted to wait for 3 years before having another child. She had used condoms but both husband and wife had been disappointed because of the method's interference with sexual intercourse. The client had not heard of any other methods apart from the pill, condoms and traditional methods. She would accept only depo provera the next time she came to the clinic. Two teachers played this role.

**Group 3** client was defined as a client in the upper thirties (35-39) and had used an IUD for three years before it was removed after an accidental pregnancy. The client had two children and wanted to stop childbearing. She could accept pills or condoms or any other methods. Teachers played this role.

### **3.3.3. Study Variables**

#### **Dependent variables**

- Client satisfaction

#### **Independent variables**

- ❖ client provider interaction,
- ❖ provider competence (knowledge, skill and experience),
- ❖ information about methods,

- ❖ re-contact and follow up mechanism,
- ❖ clients respected by providers, staffs
- ❖ Availability of logistics and supplies.
- ❖ Cleanness of the room,
- ❖ Comfortable waiting area,
- ❖ Visual and auditory privacy

### **3.4. Data Processing and Analysis Plan**

Once the data is collected and coded, it was entered in to computer and processed using SPSS version 20 software. Data cleaning were executed by using frequencies and cross tabulations to check accuracy, outliers, consistencies, and missing values. To determine satisfaction of respondents by the service provision, 11 satisfaction questions like agreement on waiting time, information obtained from providers, privacy etc was recoded and scored. The mean score was calculated and those who scored equal and above the mean were categorized under “satisfied” and those who scored below the mean were categorize under “dissatisfied”.

Bivariate analysis was used to assess chi-square test and calculating p-value. The p-value was used to identify the association between the independent variables and dependent variable that would be retained for further analysis at the multivariate stage. Further, Binary logistic regression technique was applied to identify the relative importance of each independent variable by controlling the effect of other variable. In this case the dependent variable under consideration was dichotomous which takes the value of 0 for dissatisfied and 1 for satisfied. Therefore, binary logistic regression model was the appropriate model. Multivariable logistic regression predicts the log of odds of the dependent variable as a linear function of the independent variables. The logistic model for K independent variables ( $X_1, X_2, X_3, \dots, X_k$ ) is given as (Julie, 2004)

For the purpose of analyzing the data conveniently, the information which was obtained using observation, provider interview, and facility audit and mystery client were summarized quantitatively using percentage and triangulated with quantitative findings (client exit interview).

### **3.5. Pre Test**

The pre-test of the questionnaire were carried out in one woreda outside of the selected woredas that has similar socio-demographic characteristics with the people in the selected woreda. After facility based survey was conducted to identify women who meet the inclusion criteria, study subjects were identified and the questionnaire was administered. Then after, both the interviewers and the supervisors assess clarity, understandability and completeness of the questions. The feedbacks that had obtained from the pretest contributed to the improvement of the questionnaire before final use, such as; adjusting the order of questioners, amending leading questionnaires and including additional questions.

### **3.6. Ethical Consideration**

Informed verbal consent was secured for each study subjects. Each respondent was informed about the objective of the study and assurance of confidentiality. Their names were not recorded. Women were kindly requested to be included in the study but told that it is their right to participate or not. The survey was started after written approval obtained from each service delivery points.

## **CHAPTER FOUR**

### **RESULTS**

#### **4.1. Demographic and Socio-Economic Characteristics of the Respondents**

A total of four hundred and fifteen female clients from eleven family planning service delivery points were interviewed. Seven clients did not volunteer to be interviewed. Thus, the response rate was 98.3%. Table 4.1 shows the Demographic and Socio-Economic Characteristics of the Respondents. Three hundred fifteen (75.7%) were repeat (revisiting) clients and the rest were new clients. The mean age was 28.58 (SD  $\pm$  6.8) years old ranging between 17-44 years. Most of the study participants were in the age group of 25-34 (47 %). The major ethnic groups among respondents were Oromo (47.5%) and Amhara, Tigray, Gurage and Walyta account for 31.6%, 8.9and 12% respectively. Out of the total respondents 82.4% were Orthodox Christians and the rest 17.6% of the respondents were Muslim and Protestants. About 307(74%) were married and 21.9% were never married and the rest 4.1% were separated or divorced or widowed. From those who had children, 91(30.5%), were mothers with breast-feeding at the time of data collection. The majority of the clients, 84.1% were literates and the rest 15.9 % were illiterate. Regarding to occupation, two hundred fifty six (61.7%) were housewife, 69(16.6%) were Governmental and private full time workers, the rest 90(21.7%) were merchants, farmers, daily laborers, students and unemployed. Ninety one (21.9%) of the respondents reported monthly family income of above 1000 Birr, while 15.4% reported monthly family income below 401 Birr.

**Table 4.1 Percentage Distribution of Respondents by selected background characteristics in Akaik Kality March, 2015.**

<b>Variables</b>	<b>Number(n=415)</b>	<b>Percentage</b>
<b>Age</b>		
15-24 years	128	30.8
25-34 years	195	47.0
35-49 years	92	22.2
<b>Literacy status</b>		
illiterate	66	15.9
literate	349	84.1
<b>Ethnicity</b>		
Oromo	197	47.5
Amhara	131	31.6
Tigrawai	37	8.9
Gurage and Welayta	50	12
<b>Occupation</b>		
House wife	256	61.7
Government & private employee	69	16.6
Other( <i>merchant, farmer, daily laborer, student and unemployed</i> )	90	21.7
<b>Religion</b>		
Orthodox	342	82.4
Protestant	46	11.1
Muslim	27	6.5
<b>Marital status</b>		
Married	307	74.0
Others (divorced, widowed, never married, separated)	108	26.0
<b>Average monthly family income</b>		
below 401	64	15.4
401-1000	260	62.7
above 1000	91	21.9
Number of Women with children	298	71.8
Number of Women without children	117	28.2
Repeat (revisiting) clients	315	75.9
New clients	100	24.1

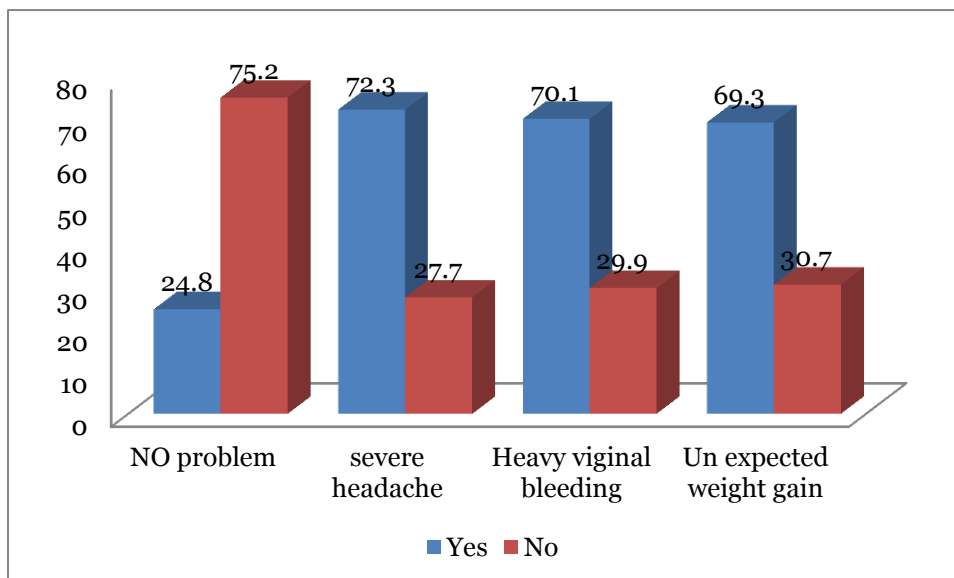
**Source: - Author's Field Survey, 2015**

## 4.2. Exit interview

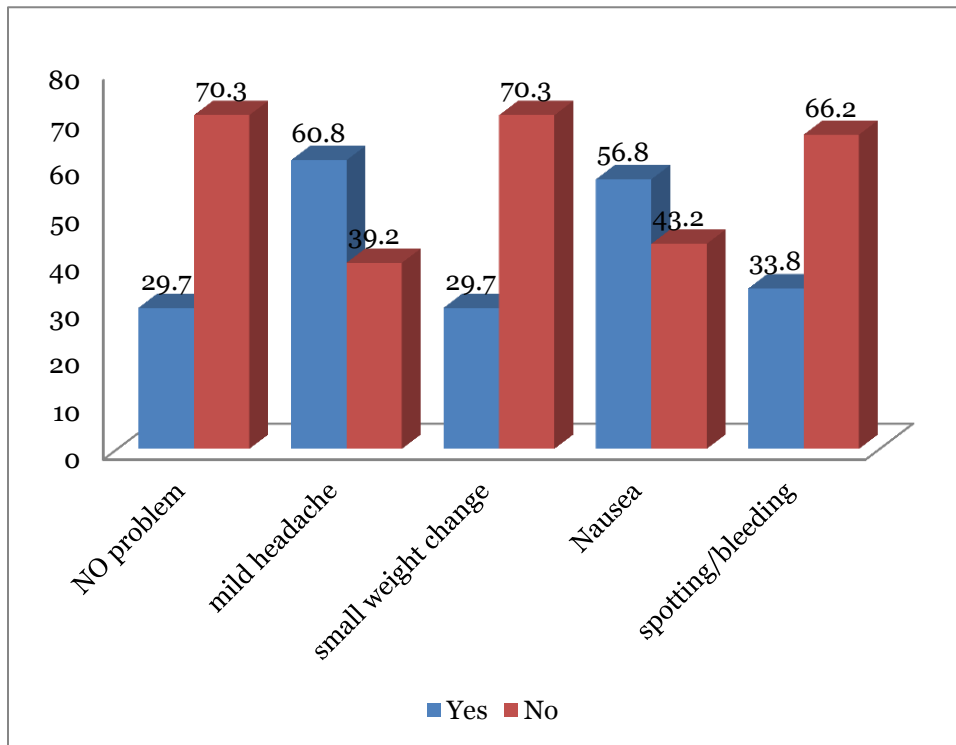
### 4.2.1. Assessment of knowledge among new & repeat(revisiting) clients

The purpose is to assess the information given to clients during counseling which has direct effect on the quality of FP services and clients satisfaction. Among injectable users, 184(98.9%) understood how often they could get their injection. More than half 100 (54.3%) of injectable users knew about the importance of this method. Concerning the problems and side effects 120(64.5%) responded that they would return to the health institutions if problem arises apart from their regular visit. Some of the problems mentioned were, severe headache 133(72.3%) and excess vaginal bleeding 128(69.6%). Regarding the next visit, 183(98.3%) knew their exact revisit day, the rest were hesitating to mention the exact day to revisit the clinic. From all 74 pills users, 73(98.6%) knew when and how to start their first pill, the rest hesitated to tell the exact time when to begin, 98% respond how often they could take the pill, and 69% mentioned the importance of pills. Out of 74 pills users, 52(70.3%) mentioned some of the problems that they may experience while taking the pills. Some of the minor problems mentioned were; mild headache 45(60.8%), small weight change 22(29.7%), nausea 42(56.8%) and spotting/bleeding between menstrual period 24(33.8%). From the total of 137 implant users 108(78.8%) were told about the importance of implant. Regarding the side effects of implant, 34(24.8%) clients responded that implant had no problem, 99(72.3%) severe headache, 96(70.1%) heavy vaginal bleeding, 95(69.3%) unexpected weight gain.

**Figure 3. The percentage distribution of Clients' knowledge on the side effects of Implanon in eleven SDPs in Akaki Kality Sub city, March, 2015.**



**Figure 4. The percentage distribution of clients knowledge on the side effects of Pills in eleven delivery points in Akaki Kality Sub city, March, 2015.**



#### **4.2.2. View of clients on the waiting time of health service delivery points**

Of 415 clients 178 (42.9%) responded that they had less than ½ hour waiting time until they get the service, 151(36.4%) had ½ to 1 hour waiting time. Client waiting time was recorded and the mean waiting time was 31.6 min with a range of 3 min to 2:40 hours.

**Table 4.2. The waiting time of clients in eleven service delivery points in Akaki kality sub city, March, 2015**

variable	Time	Frequency	Percent
How long did you wait between the times you first arrived to the clinic and gets family planning service?	Less than 1/2 hr	178	42.9
	1/2 to 1 hour	151	36.4
	Above 1 hour	86	20.7
	Total	415	100.0

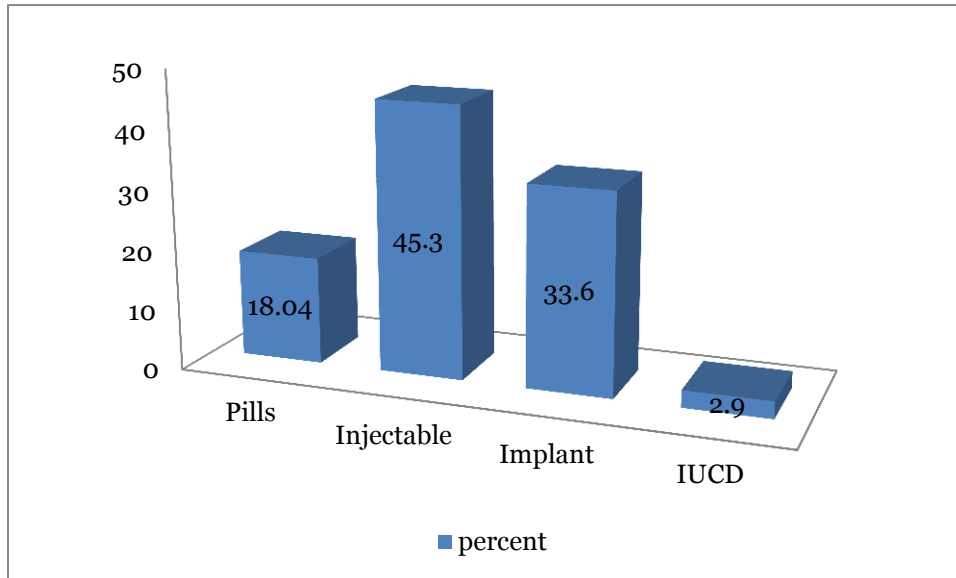
#### **4.3. The Quality Elements in the Family Planning services (Exit interview)**

Client satisfaction is, a measurement that is affected by quality elements of family planning service, assessed in terms of clients' perception using the six elements: choice of method, information given to clients, technical competence, client provider interaction, mechanism to encourage continuity and appropriate constellation of services.

##### **4.3.1. Choice of Methods by family planning users**

The majority family planning service delivery points offer primarily four methods-the Injectable, Implant, pills and IUCD. However, the dominant method was injectable 186(45.3%). Close to injectable, the second dominant method was Implant 138 (33.6%), pills 74(18.04%) and IUCD 12(2.9%).

**Figure 5. The percentage distribution of contraceptive methods by family planning users in eleven service delivery points in Akaki Kality Sub city, 2015.**



#### **4.3.2. Information Given to the Clients**

Two hundred seventy five clients (66.2%) responded that they had received enough family planning services that they wanted and the rest 140 clients claimed that they did not receive the service they wanted. The reason for dissatisfaction was the method they wanted was not available (28.6%), the provider was not interested (32.1%), due to shortage of time (39.3%),

Out of 100 new clients, 68% responded that explanation was given on how the method works, 100% on how to use the method, 67% about side effects of the methods, 57% on when to return if problems arises, 54% on the possibility of changing methods if the method is not wanted by the clients, 95% where to go for resupply and 64% of them responded that explanation of other methods was made in addition to the method they received. During explanation of methods, least attention was given to condoms (14%) and emergency contraceptives (9%). Natural contraceptive methods, spermicidal, diaphragm and female sterilization were not mentioned at all. Explanation of methods to new clients is indicated in table below.

**Table 4.3. Information given to new clients in eleven service delivery points, in Akaki kality**

**Sub city, March, 2015.**

Information given to clients	No	Percent
How the method works?		
Yes	68	68
No	22	22
Demonstrate how to use it?		
Yes	100	100
No	-	-
Describe possible side effects?		
Yes	67	67
No	33	33
Explain what to do if you experience any problems before the next visit?		
Yes	57	57
No	43	43
Explains the possibility of changing method if you are not happy with it?		
Yes	54	54
No	46	46
Where to go for supply or follow up visit?		
Yes	95	95
No	5	5
In addition to the method you received, were you told about any other methods?		
Yes	64	64
No	26	26
Total	100	100

#### **4.3.3. Client Provider Interaction**

About 268 (64.6%) clients responded that time to communicate with provider was about right, 147(35.4%) said time was short. Three hundred thirty five (80.7%) clients responded provider was easily understandable, 80(19.3%) said difficult to understand.

Hundred seventeen clients asked service provider some questions about contraceptive methods they were provided, out of these 98(83.8%) were satisfied with the answer given by service provides, 9(7.7%) partially satisfied, and 10(8.5%) were not satisfied. Privacy was maintained for 292(70.3%), the rest 123(29.7%) were dissatisfied and enough privacy was not maintained. Clients' satisfaction was identified by each family planning service delivery points and finally described by Governmental and private/NGO. For private clinics; the response of understanding service providers by clients was about 81%, agreement of consultation time 57%, and agreement on maintaining of privacy was 99%, while for Governmental Clinics as indicated in the table. Clients in the government facility agreed that consultation with the service provider was about right as compared to clients in private and NGO health facility. On the other hand clients in the government health facility claimed that maintaining of privacy during consultation was not adequate as compared to private and NGO health facility.

**Table 4.4. Client provider interaction in eleven service delivery points in Akaki kality sub city**

		Health institution				
		health center(259)	government hospital(40)	private hospital(25)	private clinic(71)	NGO health facility(20)
During consultation, was the provider easy to understand?	Easy to understand	202(48.7%)	34(8.2%)	22(5.3%)	55(13.3%)	17(4.1%)
	Difficult to understand	57(13.7%)	6(1.4%)	3(0.7%)	16(3.9%)	3(0.7%)
Did you feel that your consultation with the service provider was	About right	175(42.2)	27(6.5%)	15(3.6%)	41(9.9%)	10(2.4%)
	Too short	84(20.2%)	13(3.1%)	10(2.4%)	30(7.2%)	10(2.4%)
Was there adequate privacy during consultation?	Adequate	140(33.7%)	37(8.9%)	25(6.0%)	70(16.9%)	20(4.8%)
	Not adequate	119(28.7%)	3(0.7%)	-	1(0.2%)	-

#### 4.3.4. Technical Competence

Three hundred seven (74%) of the clients responded that the provider had good knowledge and skill in explaining and providing the method they had accepted.

#### 4.3.5. Mechanism to Encourage Continuity

Three hundred ninety-four (96%) clients were given written reminder for their next visit which helps the clients to come again to those delivery points at the right time.

#### 4.3.6. Appropriate Constellation of Services

The integration of the FP program in to the maternal and child health care reflects an appropriate constellation of services. In this study clients were asked whether any other health issues were discussed during consultations or not. Sixty one percent of clients responded that the service providers talked about abortion and 52 % about immunization and less than fifty percent of clients responded that the service providers talked about postnatal care in addition to family planning services.

**Table 4.5. Overall client satisfactions on quality of family planning services with set of 11 yes/No questions as reported by women in 11 service delivery points, in Akaki Kality sub city March, 2015**

Variables	Yes	No
1. Information given about the method was sufficient.	271(65.3%)	144(34.7%)
2. Provider had good knowledge and skill to perform the Procedures.	307(74%)	108(26%)
3. Treated in a friendly and respectful way by provider	330(79.5%)	85(20.5%)
4. You had sufficient visual and auditory privacy during counseling	292(70.4%)	123(29.6%)
5. Had the opportunity to ask questions and clarity	117(28.2%)	298(71.8%)
6. Sufficient methods were available.	350(84.3%)	65(15.7%)
7. The provider gave you a reminder mechanism for your next visit.	399(96.1%)	16(3.9%)
8. The health facility was clean.	359(86.5%)	56(13.5%)
9. The waiting area was comfortable.	276(66.5%)	139(33.5%)
10. Treated in a friendly and respectful way by other staff.	272(65.5%)	143(34.5%)
11. Waiting time was adequate.	308(74.2%)	107(25.8%)

**Figure 6** a pie chart that shows the overall client satisfaction on quality of family planning services in eleven SDPs, in Akaki Kality sub city, March, 2015.



**Note:** Of 11 quality measurement items, those clients who scored  $\geq 6$  were designated as satisfied and  $\leq 5$  were designated as dissatisfied. Hence, three hundred nineteen (76.9%) clients were satisfied on the overall family planning services and ninety six (23.1%) clients were not satisfied.

#### 4.4. Bivariate Analysis

The association of dependent and independent variables were computed and statistically significant association were observed in bivariate logistic regression between availability of sufficient method, treatment of clients by other staff, auditory and visual privacy during counseling, comfortable waiting area, cleanness of the room, information given about the method and client satisfaction at  $p\text{-value} < 0.05$ , whereas knowledge and skill of the provider, treatment of clients by provider and waiting time were not found to be significantly associated with client satisfaction ( $p\text{-value} > 0.05$ ).

Accordingly, availability of sufficient methods is significantly associated with client satisfaction ( $p < 0.001$ ). Clients who had no sufficient methods were less likely to be satisfied as compared to clients who had sufficient methods (COR= 0.271, 95% CI = 0.155 - 0.473). Treatment of clients by other staff is also significantly associated with client satisfaction ( $P < 0.01$ ). Clients who were not treated well by the other staffs were less likely to be satisfied compared with clients who were treated well (COR= 0.127, 95% CI = 0.076 - 0.211).

Sufficient visual and auditory privacy is also associated with client satisfaction in the study area ( $p < 0.001$ ). Clients who had no privacy were less likely to be satisfied compared with clients who had privacy during counseling and examination (COR= 0.092, 95% CI = 0.055 - 0.155).

Waiting area has also shown a significant association with client satisfaction ( $p < 0.001$ ). clients who had no comfortable waiting area were less likely to be satisfied as compared to clients who had comfortable waiting area (COR= 0.144, 95% CI = 0.087 - 0.238).

Cleanness of the room is also significantly associated with client satisfaction ( $p < 0.01$ ). clients who found the clinic room clean were more likely to be satisfied as compared to clients who found the clinic room not clean (COR= 0.256, 95% CI = 0.142 - 0.459). Finally, clients who were informed about the method they adopted were more likely to be satisfied as compared to clients who were not informed about the method they adopted (COR= 0.104, 95% CI = 0.062 - 0.177).

#### **4.5. Multivariate Analysis**

Applying multivariate logistic regression analysis by controlling confounding variables: treatment of clients by other staff, auditory and visual privacy during counseling, comfortable waiting area, cleanness of the room, information given about the method were significantly associated with client satisfaction (Table 4.6).

The binary logistic regression analysis showed that clients who were not treated well by the staff other than the service providers were less likely to be satisfied than clients who were treated well (AOR=0.029 and 95%CI=0.014, 0.057). Likewise, clients who had no audio and visual privacy during counseling and examination were less likely to be satisfied as compared to clients who had privacy (AOR=0.018 and 95%CI= (0.009, 0.036). Furthermore, clients who had no comfortable waiting area were less likely to be satisfied than clients who had comfortable waiting area (AOR=0.595 and 95%CI=0.372, 0.951).

With regard to cleanness of the room, the binary logistic regression result showed that clients who were not happy by cleanness of the room were less likely to be satisfied than clients who were happy by the cleanness of the clinic room (AOR=0.116 and 95%CI=0.053, 0.255). Finally, clients who were not informed about the method they adopted were less likely to be satisfied than clients who were informed (AOR=0.041 and 95%CI= 0.022, 0.077).

Table 4.6. Logistic Regression Results of Selected Variables in Relation to Client Satisfaction at 11 Service Delivery points, in Akaki Kality sub city March, 2015.

Variables	Client Satisfaction		COR(95%CI)	AOR(95%CI)
	Satisfied	Dissatisfied		
<b>The provider had good knowledge and skill</b>				
Yes	260(84.7%)	47(15.3%)	1.00	
No	59(54.6%)	49(45.4%)	0.218 (0.133, 0.355)	-
<b>Sufficient methods were available</b>				
Sufficient methods	284(81.1%)	66(18.9%)	1.00	1.00
Insufficient methods	35(53.8%)	30(46.2%)	0.271(0.155, 0.473) *	1.016(0.288, 3.579)
<b>Had the opportunity to ask question</b>				
Yes	284(81.1%)	66(18.9%)	1.00	-
No	219(73.5%)	79(26.5%)	0.644(0.265, 0.837)	
<b>Treated well by other staff</b>				
Treated well	244(89.7%)	28(10.3%)	1.00	1.00
Not treated well	75(52.4%)	68(47.6%)	0.127(0.076, 0.211)**	0.029(0.014, 0.057)**
<b>Had sufficient privacy</b>				
Sufficient privacy	263(90.1%)	29(9.9%)	1.00	1.00
No privacy	56(45.5%)	67(54.5%)	0.092(0.055, 0.155)***	0.018(0.009, 0.036)***
<b>Treated in a respectful way by provider</b>				
Treated respectfully	268(81.2%)	62(18.8%)	1	-
Treated rudely	51(60%)	34(40%)	0.347(0.207, 0.580)	
<b>The waiting area was comfortable</b>				
Comfortable	245(88.8%)	31(11.2%)	1.00	1.00
Not comfortable	74(53.2%)	65(46.8%)	0.144(0.087, 0.238)***	0.595(0.372, 0.951)***
<b>The clinic room was clean</b>				
Clean	290(80.8%)	69(19.2%)	1.00	1.00
Not clean	29(51.8%)	27(48.2%)	0.256(0.142, 0.459)**	0.116(0.053, 0.255)**
<b>Informed about the method</b>				
Informed	246(90.8%)	25(9.2%)	1.00	1.00
Not informed	73(50.7%)	71(49.3%)	0.104(0.062, 0.177)***	0.041(0.022, 0.077)***
<b>Waiting time was adequate</b>				
Adequate	253(82.1%)	55(19.7%)	1.00	-
Inadequate	66(61.7%)	41(38.3%)	0.350(0.215, 0.569)	

\* = P < 0.05 \*\* = P < 0.01 \*\*\* = P < 0.001; Source: - Author's Field Survey, 2015

## **4.6. Observation**

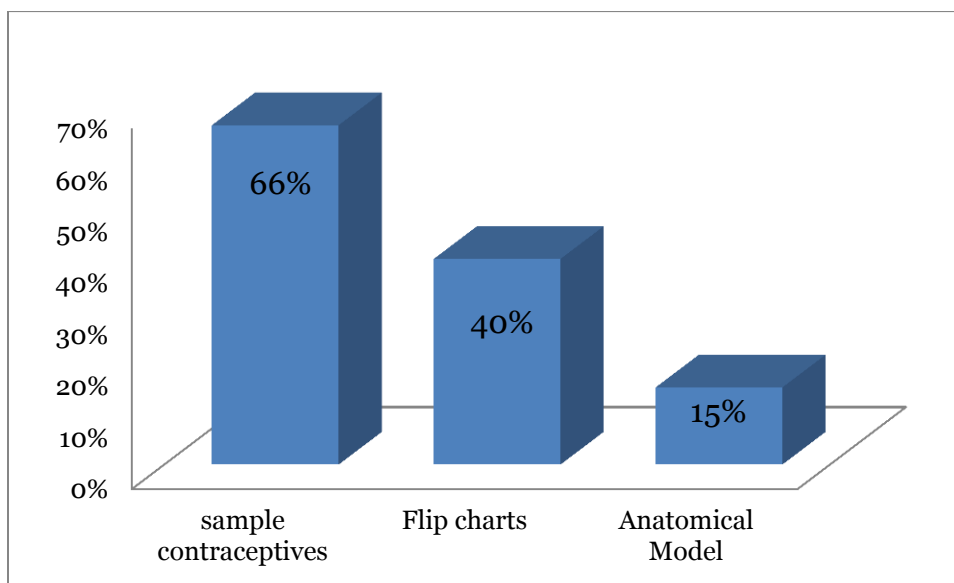
### **4.6.1. Provider Competence**

The assessment of indicators for quality of family planning care on provider knowledge and skill were observed for 100 new clients by using the recent national guideline for FP service in Ethiopia as a judgement tool. The family planning service routine activities were observed in eleven service delivery points while 7 males 7 females' service providers were giving service in one Governmental Hospital, five Health Centers, 3 private clinics, one private Hospital and in one Non-Governmental health center. A respectful and friendly way greeting was offered for a total of 49 (49%) clients. The mean waiting time for observation was 12 minutes, ranging from 3 minute to 30 minutes. Out of the new clients, 74(74%) got their choice of preference. During consultation of the new clients, IEC materials like flipchart 40(40%), different contraceptive methods 66%, and anatomical models 15% were used by providers to explain about the preferred methods.

In all governmental SDPs, at least one visual aid was used by the service providers except one governmental SDPs but no IEC material was used by providers in private health facilities for demonstrating use of FP methods at facility. Even though more than two IEC materials were available in most of governmental SDPs, it was underused by the service providers. But IEC materials were unavailable in 3 private and one government health facilities. Regarding the technical skill of the providers, observation was made to check whether the providers took (asked) or not about the following during physical exam; blood pressure, weight, asked about STI symptoms, asked about chronic illness and asked about LMP. Accordingly, common procedures observed for new clients were; asked about LMP for 100 (100%) clients, took weight for 84(84%) clients, took blood pressure for 82(82%) clients, asked about STI symptoms for 79(79%) clients and asked about chronic illness for 73(73%) clients. Regarding pelvic examination, 12 clients were examined by family planning service providers. Techniques of providers were observed while they were doing pelvic examination. Out of 12 clients who took pelvic examination, 9 (75%) clients were informed about the procedure, no providers wash hands before and after the procedure, outcome was informed for 10(83.3%) service users, speculum and uterus sound was used for all clients, sterile procedure was used by all providers and emotional support was given for 8 clients only .Of 100 new clients, all of them were told how

they use the method, 71% of them about the advantage of the method, 73% of them about the disadvantage, 59% possibility of switching the method, 53% of them were told to return if problem arises and almost all of were told where to go for re supply by the providers. As the above data indicated, providers gave little attention about the warning signs of the methods. Improvements in counseling on warning signs could reduce negative health outcomes and discontinuation of family planning services.

**Figure 7. The percentage distribution of IEC materials used for new clients in Akaki kalaita sub city, in eleven service delivery points, March, 2015.**



Out of 100 new clients 96 accepted contraceptives during the day of their visit, of which 48(50%) were injectables contraceptive users. Techniques of providers were observed while they were performing injection procedures such as; wash hands with soap before giving injection, use newly sterilized needle, stir bottle before drawing dose, allow dose to self-disperse instead of massaging, dispose of needle in puncture resistant container. All providers disinfect injection site, in addition to that, all providers maintain sterile technique by using new needles and syringes. In all cases DEPO vials were well shaken before drawing in to the syringes. All providers did not massage injection site after giving DEPO injection. However, all providers did not wash their hands with soap before giving injection and dispose of needle in puncture resistant container was performed in 27(48.2%) cases after injection. Moreover, all providers in the government health facilities did not use gloves while they were giving injection.

Appropriate use of gloves, washing hands before and after procedures and proper disposal of sharp objects in puncture resistant containers are also important for preventing infections. Gloves were not used in all of government health facilities while performing injectables even if gloves were available. Proper disposal of sharp objects was not made in 51.8% of the cases. Washing hands with water before and after performing the procedures was not conducted in more than 80% of the cases, because running or tap water was not available in the majority of health facilities.

At the end of all procedures, all providers gave some form of written reminder for clients for the next revisit. Other issues were also discussed during consultation time, for example, abortion, sexually transmitted diseases, immunization for family planning users. The information was, 88%, 82%, 74 %, 63%, 17% and 11% for injectable, implant, IUCD, condom and emergency contraceptives respectively, but no information was given about permanent contraceptives, natural method and others. This may be the providers were biased on the provision of information for few FP methods . There was difference on information provision between private and Governmental health service delivery points on different methods.

#### **4.6.2. Functional capacity (logistics and supplies)**

Eleven family planning service delivery points were observed to measure the availability of different family planning equipments which are useful and influential in providing quality family planning services effectively.

##### **4.6.2.1. Infrastructure**

Generally speaking, the waiting areas for clients had functional toilets, adequate seats and were protected from sun & rain but the waiting area of four (36.4%) health facilities had no adequate seats and it was not protected from sun, rain and wind. Moreover, the majority of the toilets in the government health facilities were with poor sanitation. The official opening time for 6 Governmental health service delivery points was from Monday to Friday 8.30am in the morning & 1.30pm in the afternoon. One Non-Governmental health center was functional from Monday to Friday from 8.00 to 12.00am in the morning & 1.00 to 4.30pm in the afternoon. One private hospital and three private clinics provide family planning services for 24 hours from Monday to Sunday. In all governmental health facilities there was a sign announcing that family planning

service was available but in one NGO health facility and private hospital there was no sign announcing that family planning service was available. Three governmental health service delivery points did not have sufficient service providers but in all private clinics there was sufficient staff assigned to work in family planning service. Except one governmental health centers, all government health facilities did not have a separate room for providing counseling and other procedures as a result, two clients would get services at the same time, which means, when one of the clients got an implant being inserted, the other client was being counseled specifically in areas where there was high waiting time or client volume. On the other hand, most health facilities refilled out of stock supply in less than a week time but some government health facilities were continuously supplying without interruption. Light source was available in all health facilities but lamp light was available in one government facility and generator was unavailable in all governmental SDPs in case of power blackout and water was unavailable in 81.8% of the SDPs in the examination room. All of the health service delivery points had registration books for recording multiple revisits or for new clients. The condition of recording system was good in all Governmental and private clinics, but they don't use it for tracing of defaulters. In general, all family planning service delivery points did not have any means of tracing defaulters.

#### **4.6.2.2. Logistics and supplies**

Three private and one governmental health facilities did not have any teaching aids. On the other hand five governmental health facilities had at least two IEC materials, but in most

Governmental health facilities, sample contraceptives were the one commonly used. Regarding FP equipments, blood pressure apparatus and weight scale were available in all health institution and an antiseptic solution was not available in one governmental and NGO health facility. Sterilizers were available in all SDPs except two governmental and one non-governmental clinics. Uterine sound was not available in one NGO clinic and in two governmental clinics, while speculum and tenaculum were not available in two governmental and one non-governmental health facility, but IUCD equipments were shared with other departments in all private SDPs. Examination tables were available in all health service delivery points. Gloves was available in all health facility except at one government health center and the clients were obliged to buy from the health center's pharmacy for five birr, this happened because of the fact

that, the service providers were so careless to bring the gloves from the storage facility, disposable needles and syringes were sufficiently available in all health facility. All health institutions had laboratory units and pregnancy test. Minor surgery equipments were available in all SDPs except two facilities.

Availability of contraceptive methods were assessed in each health institution and among the family planning methods, only injectables was available in all health delivery points. Combined oral Pills were available in all health facility except one government and one private health facilities while implanon were also available in all health facility except one government and one NGO health facility and IUCD was also available in all health facilities except two government and one non-governmental health facility. Progesterone only pill were present in all health institution except one private clinic. The procedure for tubal ligation or permanent sterilization was not carried out in all health institution. In most service delivery points, the general condition of the physical examination room was good. Stores were protected from sun, rain, wet, and rats. In most Governmental family planning SDPs, contraceptive methods were stored in the same shelf with other drugs but isolated in separate area. The availability of written guidelines and protocols for delivering family planning counseling service was observed in 72.7% of the SDPs, but the majority of the service providers did not refer it while they were counseling the clients. All government SDPs had written guidelines.

#### **4.6.2.3. Management & Supervision**

Awareness of management process was measured by the availability of documents and supervision. These documents were satisfactory almost in all service delivery points. All family planning service delivery points had monthly statistics reports about family planning activities and supervision was also made. Supervisory visit was made for all Service delivery points within the last 2 months of data collection but 54.5% of the health facilities did not get feedback. All health facilities had daily registration books except one government health facility.

#### **4.6.2.4. Follow-up or Continuity Mechanisms**

After receiving the contraceptive methods, most clients were given some appointment card with the date for revisit and told when to return. In all health service delivery points, no system was designed for follow-up to clients who return. Providers informed all new clients when to return

to the clinic for re-supply or check up. Referral system is good but more than 70% of health service delivery points did not receive feedback on report. During observation, there was no punctuality in most governmental health service delivery points. In one Non-Governmental facility, even though the official opening time was 8 AM, in some days they started to provide contraceptives at 9 AM. The same is true for governmental clinics; it started providing family planning services at 9 AM while the clients were waiting, although the official opening time was 8:30 AM.

#### **4.7. In-depth Interview**

An in depth interview was carried out to assess the knowledge and skill of family planning service providers. Fourteen family planning service providers, who were found during the day of data collection, were interviewed and responded to the questions. Out of 14 service providers, 4 of them were degree graduates in Health Officer and 9 of them were nursing graduates (8 diploma and 1 degree) and one of them was a medical doctor. The average service year in family planning program was 1 year with a range of 0 to 5 years. Eight family planning service providers had training; 5 of them had trained on long acting contraceptive methods and 3 of them on adolescent family planning. Almost all trained providers were from private health service delivery points. Half of them had trained before two years and the other half trained before 1 year. Knowledge and skill questions were asked on each specific contraceptive method for family planning service providers. For injectables and oral pills all provides had good knowledge and skill especially on providing injection, and at least they mentioned two side effects, contra indications, importance, advantage and disadvantage for both methods. All family planning providers knew when to start contraceptive method for the first time. Out of 14 providers, nine providers performed the Implant procedure but all providers mentioned side effects, contra indications, importance, advantage and disadvantage of the method. Regarding IUCD, only three providers performed the procedure, but all providers mentioned the side effects, contra indications, importance, advantage and disadvantage of IUCD. But two providers could not explain about side effects of IUCD. For permanent method, all providers did not have the skill to perform the procedure.

For exclusive breast-feeding mothers all providers replied that they provided them with only progesterone containing pills, DEPO, Implanon and IUD based on the clients choice of method

but they did not provide the combined oral contraceptive pills (COC) since it reduces the production of milk. All family planning service providers knew when to start contraceptive methods for the first time. For one missed pill, all providers said that they would advise their clients to take it as soon as they remember and continue the rest as she was doing before or to take the next day twice the normal dose. For two missed pills, all said again advise the clients to take them as soon as they remember except five providers who said that they advise them to add some more barrier methods like condom. For 3 or more missed pills, again two provides said that clients should be supported by barrier methods, 3 of them suggested to stop sexual intercourse, the rest three said they should stop taking pill. For the question “how the client check whether the IUCD is in place or not”, almost all providers in the government health facility responded that they had to check the expulsion of IUCD during menstruation on the sanitary pad, but the provider in the private sector said that the clients should check the IUCD by inserting her clean finger in to her sex organ and feeling the thread. Concerning the problem, which is beyond the capacity of the providers, all replied for referral of clients to higher health institution. Finally, all family planning service providers were asked about factors that affect the provision of quality FP services. In three governmental SDPs there was complaint about lack of man power. In five governmental health facilities there was lack and unavailability of family planning equipments. The other problem mentioned by the service providers was shortage of training. Finally the majority of service providers complained that the misconception and false rumors among the society on long term family planning methods made the clients not to make informed choice which help the clients to meet their reproductive needs safely and effectively.

#### **4.8. Mystery Client**

The primary interest of this method was to assess the interactive process between providers and clients, waiting time and general hygienic conditions at the clinics. Concordance between simulated clients and consistency with the other qualitative information was evaluated. After visiting the clinic, the simulated clients were required to fill the questionnaires to assess the quality of family planning services at the clinics that they visited. Six mystery clients visited each facility. The simulated clients managed to go through all the clinics with no detection of their roles. Careful spacing of their visits to SDPs had to be done in order to maintain anonymity.

The mystery clients reported that the waiting time was ranging from 3 min to 2:12 hr and 72.7 % of the clients reported that the provider did not greet them but all of them were given a place to sit during counseling. On the other hand 40.9% of the clients reported that there were other clients in the clinic apart from the providers in which their presence was not acceptable to maintain privacy.

Out of 66 observation by mystery clients, 39(59.1%) of the clients reported that they were asked about their age, 63.6% about their family size, 65% about their reproductive intentions, and 74.2% about their past contraceptive experience.

Regarding the choice of method, 97% of the clients reported that they were asked by the provider if they were interested in adopting a particular method but only 42(63.6%) of clients discussed those methods with the provider.

Of all the mystery clients' observation, only 6.1% of them reported that they were told by the provider that they could use condoms to protect themselves against sexually transmitted diseases and unwanted pregnancy. Out of 66 observations, in only four cases that client in the age group of 20-22 was told about the dual use of condoms. This is one of the constraints which was revealed by the study. On the other hand, no clients in the age group 35-39 were counseled about permanent contraceptive method even though, they wanted to stop child bearing.

Regarding information given to clients 60.6%, 75.5%, 83.3 % and 86.4% of clients were told how to use pills, injectables, implanon and IUCD respectively. In addition, 30.3%, 45.5%, 87.9%, and 89.4 of the mystery clients were told about the advantage of pills, injectable, implant and IUCD respectively. On the other hand, 78.8%, 81.8%, 30.3%, 22.7% of the clients reported that they were told about the side effects of pills, injectable, implanon and IUCD respectively.

Moreover, 69.7%, 81.8%, 86.4% and 87.9% of the mystery clients were told about the reversibility of pills, injectables, IUCD and Implanon respectively. The findings clearly indicated that more attention had been given to long term contraceptives by the service providers, which means, some providers were more biased by putting much emphasis on implanon and IUCD.

**Table 4.7. Information given to clients as observed by mystery clients in 11 SDPs, in Akaki-Kality sub city. March, 2015.**

Information given to clients	Pills	Injectable	Implanon	IUCD	Condoms
1.How to use the method	60.6%	75.5%	83.3 %	86.4%	4.5%
3.Advantages	30.3%	45.5%	87.9%	89.4%	6%
4.Disadvantages	69.7%	72.7%	57.6%	54.5%	-
5.Possible side effects and complication	78.8%	81.8%	30.3%	22.7%	6%
6.protection against STIs/HIV	24.2%	59.1%	48.5%	53%	6%
7.Reversibility	69.7%	81.8%	87.9%	86.4%	-

The above table showed that little attention was given to condoms. No attention was given to emergency contraceptive and any other methods during counseling by the service providers. Furthermore, the providers did not make the mystery clients to repeat any information to see whether they remembered the details or not.

Regarding the communication support material used by the providers, the mystery clients reported that, providers in private health facilities did not use IEC materials during counseling but in the government health facilities, sample contraceptives were used by all health facilities except in one health facility. Unavailability of IEC materials in the private health facilities and under utilization of the available IEC materials in the government health facilities were the constraints revealed by the study. Moreover the general hygienic conditions at the clinics was found to be good in private clinics but some governmental health facilities lack access to water and its toilets were in poor sanitation.

## **CHAPTER FIVE**

### **DISCUSSION**

This facility based cross-sectional study tried to assess qualities of family planning services at health facilities in five woredas of Akaki Kality sub city, Addis Ababa. In this study, both quantitative and qualitative research methods were employed. This study identified major constraints in family planning service delivery points, which was related to quality of family planning services. The sample size used in this study was 415 women in the reproductive age group who visited the service delivery points during data collection. Quality of family planning includes availability of services/supplies, characteristics of health care providers, adherence to the standard of care and client's expectation and perception (Farhat, 2015). In this study, factors associated with each of the three elements of quality FP service provision were examined. Therefore, the quality issues to be addressed in family planning programs at the points of structural attributes (input), service delivery (process) and the extent of client satisfaction (outcome) were looked.

#### **5.1. Structural Attributes (Input)**

Regarding the structural attributes of quality, the physical infrastructure and necessary equipment in examination rooms was observed. In all governmental health facilities, there was a sign announcing that family planning service was available, but in one NGO health facility and private hospital there was no sign announcing that family planning service was available. Regarding waiting area, the logistic regression results show that, clients who had no comfortable waiting area were 14.4 % times less likely to be satisfied than clients who had comfortable waiting area (COR=0.144 and 95%CI=0.087, 0.238). A similar data obtained from facility observation confirmed that the waiting areas for clients had functional toilets, adequate seats and were protected from sun & rain except four (36.4%) health facilities which had no adequate seats and it was not protected from sun, rain and wind, but the majority of the toilets in the government health facilities were with poor sanitation. Data obtained from exit interview also confirmed that the waiting area was comfortable for 65.5% of clients. On the other hand, light source availability is very crucial for insertion procedures and light is proper if it is lamp. Even though a light source was available in all health facilities, lamplight was available in one

governmental hospital and generator was unavailable in all governmental SDPs in case of power blackout. Moreover, tap or running water was not available in the examination room in 9(81.8%) of the SDPs which came out to be the weaker component. Regarding the necessary equipments in the examination room, blood pressure apparatus, weight scale and examination table were available in all health service delivery points and an antiseptic solution was not available in one governmental and NGO health facility. FP equipments, which was used for performing IUCD, such as; sterilizers, uterine sound, speculum and tenaculum were available in all SDPs except two governmental and one non-governmental clinics, but FP equipments, which was used for performing IUCD procedures, was shared with other departments in all private SDPs. Therefore, shortage and unavailability of IUCD equipments, as it was confirmed by the service providers, was one of the constraints identified in this study. Further, in one governmental health facility, clients were obliged to buy gloves from the pharmacy, even though; the gloves were available in the storage. This was a clear indication that the service providers were so negligent and unresponsive to clients' concern with unnecessary expense. Minor surgery equipments were available in all SDPs except two facilities but dispose of needle in puncture resistant container was performed in 27(48.2%) cases after injection which came out to be the weaker component.

It was found that all service delivery points in the study would send monthly statistical report to Akaki kaliti sub city health Bureau. Information was well documented in the daily family planning register book in all of the facilities included in the study.

Measures of management systems were satisfactory at both public and private facilities. For example, more than 54% of public and private facilities had a stock inventory that was organized and protected from sun, rain, wet, and rats.

Even though more than average numbers of FP methods were offered in public and private/NGO health facilities, female condoms, spermicidal, diaphragm, counseling about natural methods and permanent method (tuba ligation) were not offered in all health facilities. In addition to FP services, other reproductive health services such as: STIs, immunization, postnatal care and abortion care were also discussed in the majority of the cases.

The supervisory visit was good and it was made for all SDPs within the last two months of data collection but the problem was 54.5% of the facilities did not get feedback that solves the

existing quality problems. In resource poor setting, where supervision often revolves around the collection of data from the facility registers and patient records, supervision is carried out without addressing the challenges (Suh, Moreira and Ly, 2007). A study conducted in Senegal suggests that supportive supervision can improve service quality, like: improvement in infrastructure, management of staff and services, record keeping and technical competence (Suh, Moreira, Ly, 2007). Regarding the number of days services provided, governmental health facilities provided services from Monday to Friday, except one governmental hospital which provided services from Monday to Sunday, but the private facilities were better since they provided the service throughout the week. Moreover, there was no punctuality in all governmental/NGO health service delivery points; as a result, the clients were obliged to wait for 15-30 minutes after the official opening time to get the service. Although these delays were due to the time taken by the staffs at the registration desk to deliver health information, it might dissatisfy those clients who came early in the morning.

Of 14 family planning service providers, 8(57%) of them were trained on long acting contraceptive methods and adolescent family planning. However, the numbers of trained providers in the government SDPs were even smaller than private health service delivery points. Therefore, more than 50% of clients were served by untrained providers, since the public sector represents the major source of family planning services. Results from in-depth interview with the service providers confirmed that lack of training was one of the constraints in the provision of quality FP services. Further, the average number of years of experience of providers in providing FP services was 1 year ranging from zero to five years. Availability of the reference manual was above 72%, but most of the service providers did not refer it for ensuring that cases were being consulted for proper management. IEC materials were unavailable in 3 private and 1 governmental health facilities. However, five governmental health facilities had at least two IEC materials. The most dominant IEC material was sample contraceptive which was used by the government SDPs. A study conducted in Colombo indicated that IEC material was used for 38% of women using family planning service (De Silva and Fonseka, 2008). Studies conducted in Ghana and Zambia shown that more than 50% of clients were counseled by using flip charts (Kate et al, 1998).

There was no a separate room in 54.5% of health facilities for physical examination in all health facilities except one governmental and 4 private health facilities and resulted in lack of privacy in most of government health facilities since services provided in separate room are more likely to comfort clients and assure visual and auditory privacy. Therefore, this was one of the constraints which were found in this study.

## **5.2. Service Delivery (Process)**

On the other hand, at the level of service giving process, the service provider uses the available structural elements to manage the technical and interpersonal aspects of FP services. Accordingly, quality issues at the level of process were assessed in this study. The mean waiting time to get the service was 31.6 min which is lower than a study conducted in Tanzania and Kenya where the waiting time was over 40 minutes and a study conducted in Bahir Dar indicated that the mean waiting time was 48 min (Paul, Mai and Sohail, 2011 and Walle, 2005). However it is comparable to the study conducted in Jimma, East Azerbaijan and Bangladesh, that the mean waiting time was 31.7 min, 30 min and 32.5 minutes respectively (Loha, Assefa, Jira and Tessema, 2003, Mohammed, 2007 and Mendoza, Helga and Ahmed, 2001). But it is greater than the mean waiting time in a study conducted in Mekele city (15-30 min) and Hossana town 26 min (Hailay, Kalayou and \*Mekuria , 2015 and Tsegaye, Kifle and Sena, 2015). Waiting time is acceptable if is less than 30 minute and not acceptable if it is greater than 30 minute. Although the waiting time in this study is a little bit above 30 minutes, 74.2% of clients reported that waiting time was adequate.

With regard to audio and visual privacy, the binary logistic regression result showed that clients who had no audio and visual privacy during counseling and examination were 9.2% times less likely to be satisfied as compared to clients who had privacy (COR=0.092 and 95%CI=0.055, 0.155). The data from exit interview showed that visual and auditory privacy was maintained for 70.4% of clients, but a similar data obtained from mystery clients observation showed that privacy was maintained for 59.1% of clients only. A similar study conducted in Colombo and Hossana town indicated that privacy was maintained for 97% and 83.6% of clients respectively (De Silva and Fonseka, 2008 and Tsegaye, Kifle, Sena, 2015) but a study conducted in Bangladesh indicated that they were examined privately in 56% of the cases.

Of all respondents, 45.3% of the clients were using injectables followed by implants 33.6% and pills 18% which was placed in a similar rank order of clients, who were currently married, at the national level. That is, of 40 percent of currently married women using a modern method, the most commonly used modern method is injectables, currently used by 31 percent of currently married women. Five percent of currently married women use implants and 3 percent use the pill. Use of modern methods among currently married women has increased from 6 percent in 2000 to 40 percent in 2014-largely due to the sharp increase in the use of injectables, from 3 percent to 31 percent (Mini EDHS, 2014). The type of family planning method received is influenced, among other things, by knowledge about family planning methods and the availability and acceptability of the method by those who use the services. In this study, the injectable appears to be the most preferred family planning method may be because of its long term effect or because it is available in all SDPs but as most providers complained the misconception and false rumors among the society on long term family planning methods made the clients to make injectables. In using the injectable method, there is no need to worry about remembering to use it daily and it also avoids frequent visits to health institutions for supplies. In this study, almost all uneducated women were injectable contraceptive users.

Regarding information given to clients, the binary logistic regression result showed that clients who were not informed about the method they adopted were 10.4% times less likely to be satisfied than clients who were informed (COR=0.104 and 95%CI=0.062, 0.177). As results from client exit interview revealed, information given about the method was sufficient for 65.3% of clients. Studies conducted in East Azerbaijan, Iran and Bahr Dar indicated that 46%, 88.3% and 74.8% responded that they were satisfied with the amount of information they received about the use of their chosen FP method respectively (Mohammed S et al, 2007, Nanbakhsh and Salarilak, 2009 and Walle, 2005).

Data obtained from observation revealed that, the condom, which is the most important method of dual protection against unwanted pregnancy and sexually transmitted infections including HIV/AIDS, was given little attention by the service providers during counseling (less than 18%). Although the incidence and prevalence rates have shown a declining trend, there are more than 750,000 people living with HIV/AIDS. Moreover, HIV prevalence is still very high in some of the regions and peri-urban areas of Ethiopia. Additionally, there are people with high risk

behaviors (FMOH, 2015). Therefore, it is very concerning that the providers missed the good opportunity to prevent and control sexually transmitted infections. Unmarried adolescents may have more than one sexual partner that predisposes them to STIs more than older people. Hence, dual use of FP method should be included in counseling sessions (FMOH, 2011). A similar data obtained from mystery clients showed that only 6% of clients in the age group of 20-22 were counseled about the dual use of condoms. This indicated that clients were not counseled according to their socio demographic characteristics. Similarly, information given about emergency contraceptives was also very little (less than 12%). Surprisingly, counseling about natural contraceptive methods, spermicidal, diaphragm and permanent method were not mentioned at all. Moreover, no women were counseled about lactational amenorrhea even though 21.9 % of clients were breast-feeding. Thus potential clients would not be able to know about these methods and use it. This is also one of the constraints which was found in the study.

Clients, who are able to make an informed decision on their own, are more likely to be satisfied with method and continue to practice family planning (De Silva and Fonseka, 2008). Lack of information was a problem of women in the Egypt quality of care study (Jain and Bruce, 1994).

Concerning client provider interaction, 79.5% were treated in a friendly and respectful way. This percentage is lower than studies conducted in Iran, as a result, 92.5% of clients were treated politely by the service provider but it is consistent with the study conducted in Azerbaijan where 80% of the clients were treated politely by the service provider (Mohammed S et al, 2007 and Nanbakhsh and Salarilak, 2009). However, clients, who were treated well by other staff, were 65.5% only and this is consistent with the data obtained by mystery clients where the majority of observations in the age group 20-22 were treated rudely by the staff during registration. In this regard, treatment of clients by the staff other than the service provider is one of the variables that significantly influence client satisfaction. The binary logistic regression analysis showed that clients who were not treated well by the staff other than the service providers were 3.9 times less likely to be satisfied than clients who were treated well. Almost all clients in this study were encouraged to continue the use of family planning services, 96.1% of women got written

reminder for their next visit. Other studies which were consistent with this study indicated that 93% of clients in Colombo and Ghana were given a written reminder for their next visit (De Silva and Fonseka, 2008, Turkson, 2009).

Regarding the communication skill of the service provider during consultation, in this study it varies from 0% to 97.9 %, which means no women were assured verbally about the confidentiality of the consultation and the service providers discussed a return visit with almost all clients during client provider interaction. In this study providers lack such skill this is may be the providers were negligent and did not use the guide lines properly even if the guide lines were there in the majority of the government health facilities. Provider skill in communication is particularly important because a client may be more likely to continue contraceptive use if she feels comfortable with her interaction with the provider (Mohammed et al, 2007).

Regarding provider knowledge and skill on specific contraceptive methods, results from an in depth interview of providers showed that, for injectables and oral pills all providers had good knowledge and skill and at least they mentioned two side effects, contraindication, importance, advantages and disadvantages for both methods. However, two providers could not explain about side effects of IUCD. For permanent method, almost all providers did not have the skill to perform the procedure. A study conducted in Iran indicated that 86.6% women had high satisfaction with the experience of service provider (Nanbakhsh and Salarilak, 2009).

Regarding the technical skill of the providers, observation was made to check whether the common procedures were followed or not by the providers. During physical exam, the provider asked all new clients about LMP, took weight for 84% of clients, took blood pressure for 82% of clients, asked about STI symptoms for 79% of clients and asked about chronic illness for 73% of clients. In general, providers in government health facilities were better in performing physical exam procedures than private health facilities. Regarding pelvic examination, techniques of providers were observed while they were doing pelvic examination. 75% of clients were informed about the procedure, no providers wash hands before and after the procedure, outcome was informed for 83.3% of service users, sterile procedure, speculum and uterus sound was used for all clients, and emotional support was given for 66.7% of clients.

Infection prevention procedures were the most important of the evaluation process since it protects both clients and providers from spread of infectious disease. In this study observation of infection prevention procedures were assessed. Sterilized FP equipments was used by all providers but in the majority of the cases they did not wash their hand before and after performing procedures because tapped water was not available in the examination room. Gloves were not used in all of governmental SDPs while providing injectables contraceptives even if gloves were available in the facility. This was also another problem that indicated the negligence of the service providers. In addition to that, proper disposal of sharp objects was not made for more than average of the cases. In general, infection prevention procedures were not good in this study.

### **5.3. Client Satisfaction (outcome)**

Finally, at the outcome level of quality measurement, the overall client satisfaction on quality of family planning services, which was assessed based on clients' perception using the six elements of quality of Bruce-Jain frame work with their individual indexes, indicated that 76.9 % of clients were satisfied. This percentage was moderate as compared to studies conducted in other countries like Iran and Ghana. A study conducted on family planning service quality in Iran, mean satisfaction score of clients was 83.3 % (Simbar, Ahimadi, Golnoosh and Reza, 2004).

Other study conducted in Ghana on perceived quality of health care delivery, 90% of the respondents were satisfied or very satisfied with the care given during their visit to the health facility (Turkson, 2009). But it is greater than a study conducted in Eastern Ethiopia on patients perspective, the quality of hospital services on the overall satisfaction level was 54.1% (Abdosh, 2006) and less than a study conducted in Ayder sub-city of Mekelle city that means 94% of the clients responded that the quality of family planning service provided was very good or good ( Hailay, Kalayou and \*Mekuria , 2015). However it is almost similar to the study conducted in Hossana town where 75.3% of the clients were satisfied with the service they received (Tsegaye, Kifle, Sena, 2015). This variation may be of a real difference in quality of service provided, expectation of a family planning user or the type of health facilities providing the services. Studies conducted in Canada indicated that low patient satisfaction is associated with lower trust in care givers and greater chance of change of health providers resulting in less continuity of care (Tetterseil, 1993).

## **CHAPTER SIX**

### **CONCLUSIONS AND RECOMMENDATIONS**

#### **6.1. Conclusion**

In conclusion, this study demonstrated constraints in delivering quality of family planning services in health facilities.

Of all the respondents, 76.9% of clients were satisfied with the overall quality of family planning services and 23.1% of the clients were dissatisfied. The binary logistic regression results indicated that visual and auditory privacy during counseling and examination, treatment of clients by the staff other than the service provider, information given about the method, waiting area and cleanness of the clinic room had strong significant association with client satisfaction.

The waiting area was comfortable for 66.5 % of clients for the rest it lacks enough seats to accommodate client load and it was not protected from rain, sun and wind. The binary logistic regression analysis showed that clients who were treated well by the staff other than the service providers were more likely to be satisfied than clients who were not treated well. Similarly, incidents of insensitivity to privacy were isolated and did appear to be significant concerns of clients. Some of the constraints were imposed by the limitations of physical facilities (unavailability of separate room) and in an attempt to serve clients quickly some privacy concerns were not noticed.

On the other hand, data obtained from qualitative method revealed that infection prevention procedures such as; appropriate use of gloves while performing injectables procedure, hand washing before and after performing procedures and disposal of needles in puncture resistance container were not applied in the majority of health facilities. The main reasons were negligence of the service providers, shortage of resource, insufficient training and lack of supportive supervision. Not following the infection prevention procedures can have disastrous consequences for the clients as well as for the provider and should be considered as a matter of priority. This is particularly important considering the high prevalence of HIV/AIDS in the study area.

Lastly, some methods were not given the necessary attention by the service providers, for instance, condom, which is the most important method against unwanted pregnancy and STIs,

appears to get less attention, although, there are large numbers of unmarried clients who might have more than one sexual partner. No counseling was made concerning permanent methods of contraception. It seems that efficient and effective methods for limiting and spacing the number of children are neglected and those who need them may not be aware of the possibility of having such chances. Therefore, there is a need for regular training of providers to improve both the technical and counseling skills.

## **6.2. Recommendation**

To improve the quality of family planning services in the study area, the program planners, health managers and service providers should take measures based on study findings such as;

- ❖ All governmental health facilities except one health center did not have isolated rooms for delivering quality family planning services and resulted in lack of privacy in most of government health facilities since services provided in separate room are more likely to comfort clients and assure visual and auditory privacy. Therefore, efforts should be made to increase the number of health service delivery points and strengthen the existing clinics. This needs discussion with policy makers and donors to make financial investment.
- ❖ Even though almost all of the service providers have good knowledge, the majority of providers in the government health facilities are not trained. Therefore, this has to be supplemented with current training. This will help them to increase their knowledge and skill so as to avoid negligence and to be responsive to clients concern.
- ❖ Inadequate information about specific methods and less attention to audio and visual privacy were some of the constraints for client dissatisfaction. In addition to that, little attention was given to condom and emergency contraceptive and no attention was given permanent contraceptive methods, natural contraceptive method and others. Therefore, this should be improved through theoretical training.
- ❖ Waiting area of the facility should be improved by allocating budget so that waiting area seat can accommodate the average client volume and should be protected from sun and rain
- ❖ Limitations in equipments, method unavailability in some health facility, under utilization of IEC materials in governmental health facility and absence of IEC materials in private

health facilities, and absence of water in the majority of health facility should be improved through supportive supervision.

- ❖ In general, infection prevention procedures were not good in this study and should be improved through supportive supervision and training.
- ❖ Treatment of clients by the staff other than the service providers is also one of the variables that significantly influence client satisfaction and should be improved through training.
- ❖ Cleanness of health facilities specifically government health facilities should also be improved.
- ❖ Mechanisms for defaulters tracing and follow up should be designed through phone calls, home visit and other means.

## References

- AA. BoFED: Addis Ababa City Administration Finance and Economic Development Bureau: population images of Addis Ababa city 2013/14.
- Abdosh. B ;The quality of hospital services in Eastern Ethiopia; Patients' perspective; Ethiopia journal of health development,20, 199-200
- Ahmadian N, Sedigheh Y, Tavafian S, Emadzadeh A, Kazamnejad A, Ghofranipour F. Communication training and patient satisfaction. 2003.
- Bertrand Jane , Magnani Robert , Rutenberg Naomi; The evaluation Project Hand book of indicators For Family Planning Program Evaluation, December, 1994.
- Bongaarts, John and Steven W. Sinding. 2011. "Family planning as an economic investment," SAIS Review of International Affairs 31(2): 35–44.
- Bruce J. fundamental elements of the quality of care: A simple framework studies in family planning. 1990, 21 (2): 61-91
- Bruce J. Implementing the user perspective. Studies in family planning 1980; 11:29-33
- Central Statistical Agency Ethiopia Mini Demographic and Health Survey Addis Ababa, Ethiopia, July 2014.
- Central statistical authority (CSA) and united nations population fund (UNFPA), Ethiopia , summary and statistical report of the 2007, population and housing census, Addis Ababa, Ethiopia UNFPA; 2008.
- Central Statistical Authority [CSA] and ORC Macro, Ethiopia Demographic and Health Survey 2005. Addis Ababa and Calverton, Maryland: CSA and ORC Macro. 2006.
- Central Statistical Authority [Ethiopia] and ORC Macro, Ethiopia Demographic and Health Survey 2011. Addis Ababa, Ethiopia and Calverton, Maryland, USA: Central Statistical Authority and ORC Macro. 2012.
- Creel Liz, Sass Justine and Yinger Nancy. New Perspectives on Quality of Care ;Population Council and Population Reference Bureau: Overview of Quality of Care in

Reproductive Health ;Definitions and measurement of quality, July 2002,Population Reference Bureau.USA.

De Silva U, Fonseka P; Quality of care in government family planning clinic services Colombo District, December 2008.

Farhat Malik; Quality Family planning service provision at private clinics of Khyber Pakhtunkhwa province, Pakistan, 2015.

Federal Democratic Republic of Ethiopia Ministry of Health; Health Sector Transformation Plan 2015/16 - 2019/20, August 2015.

Federal Democratic Republic of Ethiopia Ministry of Health; National Guidelines for FP services in Ethiopia. February – 2011.

Federal Ministry of Health; Health Sector Strategic Plan (HSDP-IV) 20010/11-20014/15, First Draft Addis Ababa, Ethiopia June 2010.

Feleke W and Samuel G: Reproductive Health for Health Science Students, University of Gonder 2008.

FGAE: Family Guidance Association of Ethiopia, FGAE in perspective. Addis Ababa. Ethiopia: FGAE. 2000.

Getnet Mitike , Amy Tsui , Abiy Seifu , Damen H/Mariam , Mulugeta Betre , Yilma Melkamu , Mesganaw Fantahun , Solomon Kumbi , Eskindir Kebede : Quality of Family Planning Service in the Health Facilities of East Shoa Zone, Oromia Regional State, Ethiopia, 2008.

Guatemala Field Study: Assesment of the Quality of Primary Health Care: 2000.

Hailay Abrha, Kalayou Kidanu and \*Mekuria Kassa: Assessment of Family Planning Services Quality in Ayder sub-city of Mekele city, northern Ethiopia, 2015.

<http://www.who.int/mediacentre/factsheets/fs348/en/index.html>

<http://www.who.int/mediacentre/factsheets/fs351/en/>

- ICPD; Program of action Adopted at the international conference on population and development September 1994, Cairo.
- Jain A, Bruce J: A Reproductive Health approach to the objectives and assessment of family planning programmes. New York, Population Council, 1994.
- Jain AK. Fertility reduction and the quality of family planning services, studies in family planning 1989; 20: 1-16.
- Jain, Anrudh K. and John A. Ross. 2012. "Fertility differences among developing countries: Are they still related to family planning program efforts and social settings?" International Perspectives on Sexual and Reproductive Health 38(1): 15–22.
- Kate Miller, R Miller, I Askew, Mc Horn, L Ndhlovu : Clinic-Based Family Planning and Reproductive Health Services in Africa; Findings from situation analysis studies. 1998.
- Koenig, Michael A .Mian Bazle Hossain and Maxine Whittaker, 1997: The influence of Quality of Care up on contraceptive use in rural Bangladesh. Studies in Family Planning. 28 (4);278-289.
- Korra A. Quality of family planning services at the FGAE clinic. The clients' perspective. Ethiop J.Health Dev. 1997; 11(3):207-212.
- Lei, Zhen-wu, Shang Chun Wu, Rojer J Garcean, 1996; Effect of Pretreatment counseling on discontinuation rates in Chinese women given Depo-medroxyprogesteron acetate for contraception. 53(6);357-361.
- Liu R, So L, Quan H. Chinese and white Canadian satisfaction and compliance with physicians. BMC Family practice, 2007, 8:11.
- Loha E, Asefa M, Jira C, Tessema F. Assessment of quality of care in family planning services in Jimma zone, southwest Ethiopia 2003.
- Mendoza J, Helga A, Ahmed P. Client Satisfaction and Quality of Health care in rural Bangladesh, 2001, 79:512-517.

- Mesganaw Fantahun, Quality of Family Planning Services in North west Ethiopia Addis Ababa University, Department of Community Health, *Ethiop.J.Health Dev.* 2005; 19(3)
- Mohammed S et al. Quality of Family Planning Services at Primary care Facilities in urban areas of East Azerbaijan, Iran, 2007.
- Mroz, Thomas A, Keneth A.Bollen, Illene S, Speizer and Dominic Mancini,1999;Quality , Accessibility and Contraceptive use in Rural Tanzania.36(1);23-40.
- Nanbakhsh H, Salarilak F: Assesment of womens satisfaction with reproductive health services in Urmia University of Medical Science. Iran, 2009.
- Pariani, Siti, David, Heer and Maurice, Van Arsdol, Jr 1991.Does choice make a difference to contraceptive use? Evidence from East Java. *Studies in Family Planning* 22(6); 384-390.
- Paul Hutchinson, Mai Do and Sohail Agha; Measuring client satisfaction and the quality of Family planning 2011.
- Raeda Al-Qutob, Salah Mawajdeh, Laila Nawar, Salama Saidi, Firas Raad; Assessing the Quality of Reproductive Health Service: The policy Series In The Reproductive Health No.5, 1998.
- Rama Rao S, Lacuesta M, Pangolibay B, Jones H:The link between Quality of Care and Contraceptive use: *International Family Planning Perspective.*2003;29(2):76-83.
- Rathavuth H, livia M, vinod M. family planning services quality as a determinant of use of IUD in Egypt; *BMC health services research*, 22, June, 2006.
- Saumya R, Raji M:The quality of family Planning Programs; concepts, measurements, interventions and effects: *Studies in Family Planning*,vol.34,No .4 Dec.2003.pp227-248
- Simbar M, Ahimadi M, Golnoosh A, Reza B. Quality assessment of family planning services in urban health centers of Shahid Beheshit medical science university Iran, 2004.

Singh S et al. Adding It Up: The Benefits of Investing in Sexual and Reproductive Health Care: New York: The Alan Guttmacher Institute and United Nations Population Fund:2003

Suh S, Moreira P, Ly M; Improving quality of reproductive health care in Senegal through Formative supervision; results from four districts, Nov, 2007.

Tetterseil J. Asthma Patients Knowledge in Relation to compliance with drug therapy: Journal of advanced nursing, 1993:18:103-113.

TGE: The population Policy of The Transitional Government of Ethiopia. Addis Ababa, Ethiopia1993.

Tom K M, Nelson W, Wawire T, Okech C; Contraceptive use among women of reproductive Age in Kenya's city slums international journal of business and social science Vol.2 No. 1; January 2011.

Tsegaye Gebre, Kifle woldemichael and Sena Belina; Clients' Satisfaction with family planning services and associated factors among family planning users in Hossana town public health facilities; South Ethiopia; Facility based cross sectional survey,2015.

Turkson P K; Perceived quality of health care delivery in a rural district of Ghana, June 2009.

USAID, FMOH: Family planning in Ethiopia; Partners in population and development Africa regional office and health policy project 2012.

USAID/FMOH; Three Successful Sub-Saharan Africa Family Planning Programs: Lessons for meeting the MDGs. 2012.

USAID: Achieving quality for the poor in Kenya: understanding level of inequalities and barriers of family planning services, 2007, Washington D.C.

Walle Tseganeh; Assessment of Quality of Family Planning Services, Bahir-Dar special zone. Amhara regional state. MPH thesis. Addis Ababa University; 2005.

WHO; Family Planning, New York: Media Center. 2013.

WHO; Health Benefits of Family Planning; Family planning and Population Division of Family Health. 1995.

WHO; Maternal Mortality New York: Media Center. 2012.

WHO; Quality of care; A process for making strategic choices in health systems. 2006.

Williams et al; measuring family planning service quality through client satisfaction exit interviews. International family planning perspectives, 2000.26(2):57-73.

Williams T, Schutt-Aine J Cuca Y. Measuring Family planning quality;2004.

World Health Organization. 2010. Trends in Maternal Mortality 1990–2008.

[http://whqlibdoc.who.int/publications/2010/9789241500265\\_eng.pdf](http://whqlibdoc.who.int/publications/2010/9789241500265_eng.pdf)

Yetinayt Asfaw; Assessment of Quality of Family Planning Services in Addis Ababa, Ethiopia. Addis Ababa University. 1995.

## Annexes

### Annex 1: Survey questionnaire for exit interview

Questionnaire for facility based survey on Quality of Family planning services in Akaki Kality Sub-city, Addis Ababa

#### Verbal consent

Greetings

Hello! My name is \_\_\_\_\_.I am collecting data for Becka Tasew, who is a masters student at Addis Ababa University conducting a study on quality of family planning. It is believed that quality family planning service increases clients' satisfaction, which contributes to increase contraceptive prevalence rate. The purpose of this study is to assess the quality of family planning service provided in some health institutions and level of satisfaction of family planning users, and finally to give important comment that will help to strengthen and improve quality of family planning service. The interview will take about 30-40 minutes. No information concerning you, as individual will be passed to another individual or institution without your agreement. Your participation is voluntary and you have the right to not participate fully or partially. If you agree to be included in the study, only honest answers would contribute to improvement of quality family planning service.

“May I continue?”

Yes, continue interviewing

No, thank and stop interviewing

Name of the interviewer\_\_\_\_\_ Sign. \_\_\_\_\_ Date of interview\_\_\_\_\_

Name of the supervisor \_\_\_\_\_ Sign. \_\_\_\_\_ Date\_\_\_\_\_

Code number of the client -----

Residence: region, Sub city woreda -----,-----,-----

Client arrived at service delivery points-----

Time client received service-----

Waiting time-----

### Part I: Socio-demographic Background characteristics

No	Questions	Alternative choices for responses	Skip to
101	How old are you?	1.Age in years----- 88.Don't know----- 99.No answer-----	
102	Is this your first visit to this clinic?	1.yes 2.No	
103	What is your current marital status?	1.Never married 2.Married 3.Separated 4.Divorced 5.Widowed	
104	If married/have regular partner/, have you discussed about family planning with your husband?	1.Yes 2.No 99.Don't remember	
105	Do you have children?	1. Yes 2.No-----	Q 110
106	If yes, how many living children do you have?	1.One 2.Two 3.Three and above	
107	Would you like to have more children?	1.Yes 2.No 3.Depends on God 4.Depends on husband 99.No answer	
108	If yes, when would you like to have the next child?	1.Immediately 2.One - two year 3.After two years 99.No answer	
109	Are you currently breastfeeding?	1.Yes 2.No	
110	What is your educational level?	1.No education 2.Read and write only 3.Primary school(1-8) 4.Secondary school completed 5.higher	
111	What is your religion?	1.Orthodox 2.Catholic 3.Protestant 4.Muslim 5.Other(specify)-----	
112	What is your ethnicity?	1.Amhara 2.Oromo 3.Guragie 4.Tigrawai 5.Other(specify)	
113	What is your occupation?	1.Goverment employee 2.Private employee 3.Merchant 4.Un employed 5.House wife 6.Student 7.Daily laborer 8.Farmer 9.Other(specify)-----	
114	What is the average monthly family income?	Monthly income Eth.Birr-----	

**Part II: Client interview on access and acceptability of family Planning service. (For both new and repeat)**

No	Questions and filter	Coding category	Skip to
201	From where do you hear about the source of family planning service?	1.Husband/partner 2.Neighbours/ Friends 3.Health institution/HEW 4.TV/Radio 5. Other(Specify)-----	
202	How long did it take you to arrive from your home to this health institution?	1. Less than 1/2 hour 2. 1/2 to 1 hour 3. above 1 hour	
203	How long did you wait between the times you first arrived to the clinic and gets family planning service?	1.Less than ½ hour 2. 1/2 to 1 hour 3. above 1 hour	
204	How do you feel about your waiting time?	1.No waiting 2.Short 3.Long 4.Too long	
205	Did you receive the service that you wanted?	1.Yes ----- 2.No	<b>Q 207</b>
206	If no why?	1.Provider do not want to tell me 2.The service I want was not available 3.The time was too short and I did not get time 4.Other(specify)-----	
207	Did you feel that your consultation with the service provider was	1.About right 2.Too short 3.Too long 88.Don't know 99.No answer	
208	During consultation, was the provider easy to understand?	1.Easy to understand 2.Difficult to understand 3.Don't understand 99.No answer	
209	Was there adequate privacy during consultation?	1.Adequate 2.Not adequate 99.No answer	
210	Do you know any other clinic where you can get family planning service?	1.Yes 2.No 88.Don't know	
211	If yes, is this clinic the closest site to your Home?	1.Yes 2.No 88.Don't know 99.No answer	



217	In addition to the method you received, were you told about any other methods?	1.Yes 2.No ----- --- 99.No answer	<b>Q218</b>
218	If yes, which methods?		
218.1	Pills-----	1.Yes 2.No	
218.2	Injectable-----	1.Yes 2.No	
218.3	Spermicidal-----	1.Yes 2.No	
218.4	Diaphragm-----	1.Yes 2.No	
218.5	IUCD-----	1.Yes 2.No	
218.6	Condom-----	1.Yes 2.No	
218.7	Female sterilization-----	1.Yes 2.No	
218.8	Implanon-----	1.Yes 2.No	
218.9	Other(specify)-----	1.Yes 2.No	
219	Were you given additional services other than FP services?	1.Yes 2.No	
219.1	If yes which services were you provided?	1-Abortion 2. STD 3 .Immunization 4. Postnatal care 4. Other/specify	

**Part III section II; for re-supply or follow-up clients**

220	Which method are you using?	1.Pills 2.Injectable 3.Spermicides 4.Diaphragm 5.IUCD 6.Condom 7.Implanon 7.Other(specify)---- -	
<b>221</b>	Which method do you know other than the method you are using?		
221.1	Pills-----	1.Yes 2.No	
221.2	Injectable-----	1.Yes 2.No	
221.3	Spermicidal-----	1.Yes 2.No	
221.4	Diaphragm-----	1.Yes 2.No	
221.5	IUCD-----	1.Yes 2.No	
221.6	Condom-----	1.Yes 2.No	
221.7	Female sterilization-----	1.Yes 2.No	
221.8	Implant-----	1.Yes 2.No	
221.9	Other(specify)-----	1.Yes 2.No	
222	Last time you have obtained family planning method; did you get it from this clinic?	1.Yes----- 2.No	<b>Q223</b>
223	If no, where did you get it?	1.Other governmental health	

		Institution 2.Private clinic 3.Community based distribution 4.Pharmacy 5.Other	
224	Did you pay for the service and contraceptive?	1.Yes 2.No-----	<b>Q225</b>
225	If yes, how much for one visit?	1.Price for contraceptive per cycle ----- 2.Price for service-----	
226	If a friend of yours wanted family planning service, would you encourage her to come to this clinic or go elsewhere?	1.Come to this clinic 2.Go to somewhere else 88.Don't know 99.No answer	
227	If you encourage her to go somewhere else, why?		
227.1	Long waiting time here-----	1.Yes 2.No	
227.2	Far away-----	1.Yes 2.No	
227.3	Poor quality service here-----	1.Yes 2.No	
227.4	Poor/inadequate consultation-----	1.Yes 2.No	
227.5	Only few family planning methods are available here-----	1.Yes 2.No	
227.6	Other (specify)-----	1.Yes 2.No	
227.7	No answer-----		
228	Which service did you like from this clinic?		
228.1	Get service with in short period-----	1.Yes 2.No	
228.2	Provider gives good service-----	1.Yes 2.No	
228.3	Counseling was clear and satisfactory--	1.Yes 2.No	
228.4	-	1.Yes 2.No	
228.5	Received the method chosen-----	1.Yes 2.No	
228.6	Other(specify)-----	<b>1.Yes</b> <b>2.No</b>	
	No answer		

**Part IV Knowledge questions for different contraceptive methods for both new and repeat client**

**For pills**

No	Question and filter	Coding and category	Skip to
229	When do you start using pills?	1.Within the 1 <sup>st</sup> to 5 <sup>th</sup> day of menstruation period 2.Any time 88.Don't know 99.No answer	
230	How often could you take a pill?	1.One tablet everyday at the same time      2.Any time 3.During sexual intercourse 88.Don't know      99.No answer	
231	What are the minor problems, if any, you may experience with taking the pills?		
231.1	No problem-----	1.Yes                      2.No	
231.2	Mild headache-----	1.Yes                      2.No	
231.3	Small weight gain-----	1.Yes                      2.No	
231.4	Nausea-----	1.Yes                      2.No	
231.5	Spotting/bleeding-----	<b>1.Yes                      2.No</b>	
231.6	Other(specify)-----	1.yes                      2.No	
231.7	Don't know-----		

**For injectable acceptors**

No	Question and filter	Coding category	Skip to
232	Have you been told the importance Injectable?	1.yes    2.No	
233	How often should you get an injection?	1.Every month 2.Every 3 months 3.Every year 88.Don't know	
234	Apart from the regular visits, for what problem, if any, would you come back to the clinic?		
234.1	No problem-----		
234.2	Severe headache -----	1.Yes                      2.No	
234.3	Heavy bleeding-----	1.Yes                      2.No	
234.4	Other /specify/-----	1.Yes                      2.No	
234.5	Don't know-----	1.Yes                      2.No	

**For IUCD**

No	Question and filter	Coding category	Skip to
235	If intra uterine contraceptive device is inserted, can you tell me how you check it whether it is in place or not?	1.By touching the thread regularly 2.It cannot slip out once it is inserted 3.Other(specify)----88.Don't know	
236	When will you come back for the first check up?	1.No need to come back 2.Lessthan a month 3.After one month 4.After one year 88.Don't know	
237	What are the minor problems, if any, you may experience with having an IUCD?		
237.1	No problem-----	1.Yes                      2.No	
237.2	Spotting b/n menstrual periods----	1.Yes                      2.No	
237.3	Increased discharge-----	1.Yes                      2.No	
237.4	Infection-----	1.Yes                      2.No	
237.5	Other/specify/-----	1.Yes                      2.No	
237.6	Don't know-----	88	
238	Do you know how long can IUCD serve once it has been inserted?	1. 12 years      2. 5 years 3. 3 years 88.Don't know	

**Implant users**

No	Questions and filter	Coding category	Skip to
239	How often can you change an Implant?	1.Every 5 years 2.Every 2 years 3.Every 3 years 4.Every 4 years 88.Don't know	
240	Have you been told the importance of Implant?	1.yes                      2.No	
241	Apart from the regular visit, for what problems, if any, should you come back to the clinic?		
241.1	No problem-----	1.Yes                      2.No	
241.2	Severe headache-----	1.Yes                      2.No	
241.3	Heavy vaginal bleeding-----	1.Yes                      2.No	
241.4	Unexpected weight gain-----	1.Yes                      2.No	
241.5	Other/specify		
241.6	Don't know		

**Part V Overall measure of client satisfaction on family planning services/both new and repeat/**

<b>No</b>	<b>Question and filter</b>	<b>Coding category</b>	<b>Skipto</b>
242	Information given about the method was sufficient.	1.Yes                      2.No	
243	Provider has good knowledge and skill to perform the procedure.	1.Yes                      2.No	
244	Were you treated in a friendly and respectful way?	1.Yes                      2.No	
245	You had sufficient visual and auditory privacy during your consultation.	1.Yes                      2.No	
246	Did you feel that you had the opportunity to ask questions and clarity?	1.Yes                      2.No	
247	Sufficient methods were available.	1.Yes                      2.No	
248	The provider gave you a reminder mechanism for your next visit.	1.Yes                      2.No	
249	The health facility was clean?	1.Yes                      2.No	
250	The waiting area was comfortable?	1.Yes                      2.No	
251	Treated in a friendly and respectful way by other staff.	1.Yes                      2.No	
252	Waiting time was adequate.	1.Yes                      2.No	
	<b>Total response</b>		

**Annex 2: Section 1. Observation Checklist**

Observation Guide for provider client interaction

Code number of the health institution\_\_\_\_\_

Greet providers and clients; introduce yourself and the purpose of the study. Obtain the agreement of both client and provider before proceeding to observe the interaction between them. No need of intervention to be involved. For each of the question listed below, circle that represents your observation of what happened during observation.

Good morning dear provider and client!

My name is ----- . I am a member of research team on quality of family planning service, which is going to be conducted by Addis Ababa University. It is believed that quality family planning service increases contraceptive prevalence rate and the purpose of this study is to assess the status of quality family planning service in some health institutions. The finding of this study is intended to improve quality family planning service in both Governmental and non-governmental health institutions and hence to increase contraceptive prevalence rate. For this quality of family planning study, you are chosen to participate. The observation includes various techniques to evaluate your interaction. In order to attain effectively the goal of this study, I am asking you for your generous participation. I don't put your name or registration number on this questionnaire. It is your full right to refuse or participate in the study. But your honest response will contribute to generate information, which can be used to improve the quality service of family planning.

Do you agree to participate in this study?

Yes No

Code number of the client

Date of Visit

Total time required\_\_\_\_\_

Name of observer Signature\_\_\_\_\_

Checked by supervisor/investigator Signature\_\_\_\_\_

No	Question and filter	coding category	Skip to
301	Does provider greet clients?	1-yes      2-no	
302	Does client know about modern family planning?	1-Yes      2-No	
302	Does client has preference for a particular method?	1-Yes      2-No	
304	During consultation, did the provider talk about any of the following?		
304.01	Pills	1-Yes      2-No	
304.02	Injectable	1-Yes      2-No	
304.03	Implanon	1-Yes      2-No	
304.04	IUCD	1-Yes      2-No	
304.05	Condom	1-Yes      2-No	
304.06	Diaphragm	1-Yes      2-No	
304.07	Natural method	1-Yes      2-No	
304.08	Spermicide	1-Yes      2-No	
304.09	Female sterilization	1-Yes      2-No	
304.10	Other/specify_____	1-Yes      2-No	
305	Did the provider promote or overemphasize one method in particular?		
	If yes which method		
305.1		1. pills	
305.2		2. injectable	
305.3		3. Implanon	
305.4		4. IUCD	
305.5		5. condom	
305.6		6. diaphragm	
305.7		7. spermicide	
305.8		8. female sterilization	
305.9		9. no answer	
306	IEC materials used during consultation		
306.1	Flip chart	1- yes      2- no	
306.2	Brochure/pamphlets	1- yes      2- no	
306.3	Sample of contraceptive	1- yes      2- no	

<b>306.4</b>	Posters	1- yes	2- no	
<b>306.5</b>	Anatomical model	1- yes	2- no	
<b>306.6</b>	Other (specify)	1- yes	2- no	
<b>307</b>	Did the provider /counseling skills/	1- yes	2- no	
<b>307.1</b>	Ask open-ended questions	1- yes	2- no	
<b>307.2</b>	Encourage client to ask questions	1- yes	2- no	
<b>307.3</b>	Treat client with respect	1- yes	2- no	
<b>307.4</b>	See client in private	1- yes	2- no	
<b>307.5</b>	Discuss a return visit	1- yes	2- no	
<b>307.6</b>	Ask client concerns with any method	1- yes	2- no	
<b>307.7</b>	Use visual aids	1- yes	2- no	
<b>307.8</b>	Use client record	1- yes	2- no	
<b>307.9</b>	Assure client of confidentiality	1- yes	2- no	

## Section 2. medical history and physical examination

No	Question and filter	Coding category		Skip to
<b>308</b>	During consultation, did the provider ask the client on the following?			
308.1	About contraceptive method history	1- Yes	2- no	
308.2	About date of LMP	1- Yes	2- no	
308.3	Unusual vagina discharge/bleeding	1- Yes	2- no	
308.4	Pelvic pain	1- Yes	2- no	
308.5	Take weight	1- Yes	2- no	
308.6	Take blood pressure	1- Yes	2- no	
308.7	Sexual transmitted disease problems/symptoms	1- Yes	2-no	
	Asked about chronic illness	1- Yes	2-no	
308.8	Perform physical examination	1- Yes	2-no	
308.9	Did laboratory test	1- Yes	2- no	
309	During pelvic examination	1- Yes	2- no	
309.1	Client informed?	1- Yes	2- no	
309.2	Ensure client has privacy	1- Yes	2- no	
309.3	Prepare all instruments before exam	1- Yes	2- no	

309.4	Wash hands before exam	1- Yes	2- no	
309.5	Provider wash hands after exam	1- Yes	2- no	
309.6	Use sterilized or high-level disinfected instruments for each exam	1- Yes	2- no	
309.7	Ensure that instruments and reusable gloves are decontaminated	1- Yes	2- no	
309.8	Client informed about outcome?	1- Yes	2- no	

Section 3. complete the following questions for the indicated method and the likes

No	Question filter	Coding category		Skip to
310	If intra uterine contraceptive device (IUCD) was inserted	1- Yes	2- no	
310.1	Uterus sound used?	1- Yes	2- no	
310.2	Ensure client has privacy	1- Yes	2- no	
310.3	Wash hands before putting on gloves and after removing gloves	1- Yes	2- no	
310.4	Speculum used?	1- Yes	2- no	
310.5	Sterile procedure performed used?	1- Yes	2- no	
310.6	Emotional support given for client?	1- Yes	2 – no	
311	If injectable was given to the client, did the provider do the following/	1- Yes	2- no	
311.1	Injection site disinfected?	1- Yes	2- no	
311.2	New/sterile needle and syringe used?	1- Yes	2- no	
311.3	DEPO vial shaken before drawing in to syringe?	1- Yes	2 – no	
311.4	Injection site massage?	1- Yes	2- no	

311.5	Dispose of sharps in puncture resistant containers	1- Yes	2- no	
312	For the method selected did the provider told about any of the following?	1- Yes	2- no	
321.1	How to use method	1- Yes	2- no	
312.2	Advantage	1- Yes	2- no	
312.3	disadvantage	1- Yes	2- no	
312.4	Side effects	1- Yes	2- no	
312.5	Possibility of switching	1- Yes	2- no	
312.6	What to do if problem arises about method	1- Yes	2- no	
312.7	Where to go for re supply	1- Yes	2- no	
312.8	Communicated about the method	1- Yes	2- no	
313	Was the client told when to return for re supply?	1- Yes	2- no	
314	If yes, did the provider give to the client some form of written reminder?	1- Yes	2- no	
315	Were any other health issues discussed at any time during the consultation	1- Abortion 2- STD 3- Immunization 4- Other/specify		

**Annex 3: In-depth interview**

Health institution – Hospital/ Health central/ clinic/Private clinic

Code of the health institution \_\_\_\_\_

I am carrying out a survey of quality family planning service on different health institutions to find ways of improving the service. I would like to ask you some questions to get information from your experience. Please be sure that this discussion is strictly secreted, confidential and that your name is not being recorded.

**May I continue?**

Yes            No

**Thank you**

Health institution- hospital/ health center/ clinic/ private clinic

Code of the health institution \_\_\_\_\_

**Code of the service provider**-----

**Position of the respondent**-----

**Name of the health institute**-----

### **I. work experience**

Sex \_\_\_\_\_ age \_\_\_\_\_ marital status \_\_\_\_\_ educational status \_\_\_\_\_

1. How long have you been working here? \_\_\_\_\_
2. For how many years have you been providing family planning service? \_\_\_\_\_
3. What kind of training have you ever attended? /no job training/ \_\_\_\_\_
4. Do you think that the training you have received in FP is adequate to perform your duties? \_\_\_\_\_
5. What kind of training do you think that is important to improve service delivery in FP /practical, theoretical/ \_\_\_\_\_

### **II. Provider ability to perform specific contraceptive procedure**

6. Are you able to perform the following procedures?
  - 6.1. Injection of Depo-provera. Can you tell me about importance, side effect, and contra indications, pre requisition measures?
  - 6.2. Implant:- how to insert, pre requisition measures, side effects, contraindications, importance, advantage and disadvantage.
  - 6.3.IUCD:- how to insert, importance, side effect, contra-indication, pre requisition measures, follow up of clients.
  - 6.4.Tubal ligation:- how to do the procedure, it's important, pre requisition measures, who should decide.
  - 6.5.Pills:- how many (in kinds) pills do you know, importance, side effects, contra- indications, for whom each of them are applicable, pre-requisition measure for each of them

7. What is the importance of availability of different contraceptive methods?
8. If a client would like a method that is not available at your clinic, what would you say to her?
9. In professional opinion, what do you consider to be the necessary procedures and tastes? Before you can offer the method?  
(A) Pills (B) injections (C) IUCD (D) Implant (E) tubal ligation
10. Which method of F/P would you recommend for most people who would like to delay or space their next birth?
11. Which methods of F/P would you recommend for most people who would like to have no more children?
12. Which method never you recommend
13. If client comes to you for F/P service and she is breast-feeding, what advice do you tell her?
14. In addition to using contraceptive methods do you think that some women in this community use abortion to regulate their fertility? If so, how & where they perform it?

**Method specific knowledge questions.**

**A. Pills:**

15. When should a client with regular menses start taking pills?
16. If a client forgets to take pill for one or two days, what she should do?
17. What are some minor problems, if any, a client may experience with taking the pills

**B- IUCD: -**

18. When can IUCD be inserted?
19. How the client check if the IUCD is in place
20. What are the minor problems for IUCD?
21. When should an IUCD client come back for the 1st check-up after the insertion?
22. For how long IUCD is effective?

**C- Inject able**

23. When should a client start an injectable contraceptive?
24. When should a client return for the next injection?

25. What are the minor problems, if any client may experience.
26. Apart from the regular return visit, for what major problems, if any, should an injectable client come back to the clinic?

#### D- SUGGESTIONS FOR IMPROVING FAMILY PLANNING SERVICES

27. In your opinion which methods of family planning should be given priority and should be improved?
28. In your opinion, do you believe that there are adequate teaching aids for family planning clients coming to your institutions?
29. Is there a method to follow up defaulters among family planning clients?
30. If yes, which method of follow up are you using?
  
31. If a family planning client has a problem, which is beyond the capacity of the institution or if the method the client desired is not available in the institution, is there a method of referring her to a better health institution?
32. If yes, was feedback sent to you?
33. What are the factors that affect the provision of quality FP service?

**Annexes 4: Checklists for inventory**

**Instructions to data collectors:** This inventory should be completed by observing the facilities that are available and with the person in charge of family planning on the day of the visit. In all cases you should verify that the items exist by actually observing them .If you are able to observe them, then cod them accordingly. Remember that the objective is to identify the equipment and facilities that currently exist for the service and not to evaluate the performance of the staff or clinic.

**Thank You!**

Code No of health institution----- Date of visiting-----

**Code No of health institution----- Date of visiting-----**

1. What is the official opening time for this service delivery point? -----
2. How soon after the official opening time were services provided? -----
3. Are family planning services being provided on the day of the visit?
4. Is there a sign announcing that family planning services are available? -----
5. Indicate the number of staff who provides family planning services at this service delivery point on the day of the visit, within each designation(example; nurse, Dr. )-----

**Section I Equipment and Commodity Inventory**

6. Record below which contraceptive methods are usually provided at this facility. If the method is usually provided, determine if it is available at the facility today.

Type of contraceptive	Usually provides method	Available today	If no, reason not available last time
1.Combined pills	1. Yes 2. No	1. Yes 2. No	1.Supplies not available 2.Equipment not available 3.Trained staff not available 4.Other
2.Progestrone only	1. Yes 2. No	1. Yes 2. No	1.Supplies not available 2.Equipment not available 3.Trained staff not available

			4. Other _____
3.C Pill	1. Yes 2. No	1. Yes 2. No	1. Supplies not available 2. Equipment not available 3. Trained staff not available 4. Other _____
4. Injectables	1. Yes 2. No	1. Yes 2. No	1. Supplies not available 2. Equipment not available 3. Trained staff not available 4. Other _____
5. IUD	1. Yes 2. No	1. Yes 2. No	1. Supplies not available 2. Equipment not available 3. Trained staff not available 4. Other _____
6. Condoms	1. Yes 2. No	1. Yes 2. No	1. Supplies not available 2. Equipment not available 3. Trained staff not available 4. Other _____
7. Spermicide	1. Yes 2. No	1. Yes 2. No	1. Supplies not available 2. Equipment not available 3. Trained staff not available 4. Other _____
8. Diaphragm	1. Yes 2. No	1. Yes 2. No	1. Supplies not available 2. Equipment not available 3. Trained staff not available 4. Other _____
9. Other	1. Yes 2. No	1. Yes 2. No	1. Supplies not available 2. Equipment not available 3. Trained staff not available 4. Other _____

7. The waiting area was comfortable 1. Yes 2. No

8. The waiting area has functional toilet 1. Yes 2. No

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

1. One week or less

2. One month or less

3. Six months or less

4. Other \_\_\_\_\_

10. Which of the following types of equipment are available?

Types of functional equipments	Quantity	Available	Not available
1.Sterilizer			
2.Blood pressure apparatus			
3.Weight Scale			
4.Lamplight			
5.Uterine sound			
6.Speculum			
7.Scissors			
8.Teneculum			
9.Antiseptic Solutions			
10.Disposable gloves			
11.Examination table			
12.Thermometer			
14.Mini lap kits			
15.Sterile gloves			
16.Pregnancy test			
17.Disposable needles and syringes			
18.Autoclave			
19.Different contraceptive methods			
20.Minor Surgery equipments			
21. Power Generator			
22.Other (specify)			

11. Are facilities for storing contraceptives adequate in the following respect:

A. Products are protected from the rain, sun and wet.

1. Yes            2. No

B. Products are off the floor and on shelves.

1. Yes          2. No

10. Which family planning IEC materials are available?

List all that are available\_\_\_\_\_

11. Was “a health talks” held today? \_\_\_\_\_ what was the topic? \_\_\_\_\_

Who was educating (qualification)? \_\_\_\_\_

12. Is there a separate room or area for physical examination? \_\_\_\_\_

13. Is adequate light and water available in the examination room? \_\_\_\_\_

14. How was the condition of the physical examination room\_\_\_\_\_

15. Please show me the most recent version of written guidelines and protocols for delivering family planning service.

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

2. Available but not observed

3. Not available.

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

1. Yes          2. No

### **Section 2: Record Keeping and Reporting**

17. Is there a client record card for recording multiple visits or new card issued for each visit?

18. In what condition is the record card system?

19. Is there a daily family planning activity register/log book?

20. Are monthly statistic reports about family planning activity sent to a supervisor or higher unit?

21. If yes when was the last report sent? Is feedback received on report?

22. When was the last time a supervisor come here in relation to family planning?

23. Did you get feedback that solves the existing problem?

**Annexes 5; Check list for mystery client**

1. How long did you wait?

1. < 30 minutes      2. 30 minutes to 1hour      3. > 1hour

2. Were you treated well by other staff other than the service provider?

1. Yes                      2. No

3. Did the provider greet you?

1. Yes                      2. No

4. What was the attitude of the provider?	Tick if yes
1.courteous	
2.Rude	
3.Indifferent	

5. Where you given a place to sit during the counseling?      1. Yes      2. No

6. A. Were there any other person in the clinic room?

1. Yes                      2. No(skip to 8)

5B. If yes, how many? \_\_\_\_\_(number of people present)

7. Who according to your estimate were these people?	Tick if yes
1.Health staff	
2.Other clients	
3.Clients' attendant	
4.Others(specify)	
5.Don't know	

8. Was their presence acceptable for maintaining privacy? 1. Yes      2. No

9. During counseling, did the provider practice the following skill?	Tick if yes
1.Active listening (follow where the client leads discussion )	
2.Emphaty (show interest and understanding at all times)	
3.Positive regard (non-judgmental, relating on equal terms)	
4.Answer your questions	

10. Did the provider ask you any of the following questions?	Tick whenever applicable
1. Your age	
2. Family size	
3. Reproductive intentions	
4. Past contraceptive experience	
5. Switching (change of contraceptive)	
6. Abnormal vaginal bleeding	
7. Abnormal vaginal discharge	
8. Genital Itching	
9. Lower abdominal pain	
10. Others (specify)	
11. None of these Subjects	

11. Did the provider ask you if you were interested in adopting any particular method?

1. Yes      2. No

12. Did the provider discuss those methods with you?    1. Yes    2. No

13. Which contraceptive methods did the provider tell you about that you or your partner could use	Tick if yes
1. condoms	
2. oral pills	
3. spermicide	
4. IUD	
5. Emergency contraception	
6. Female sterilization	
7. Injectables	
14. What information did the provider give you about those methods? (read 1-9 and tick the answer for each specified method code). when more than two methods were discussed make additional columns and mark the answers.	

Information given		
1.How to use the method		
1.Effectiveness		
3.Advantages		
4.Disadvantages		
5.Possible side effects and complication		
6.protection against STIs/HIV		
7.Reversibility		
8.None of these issues		

15. Did the provider motivate you to adopt any particular contraceptive method?

1. Yes 2. No

16. If yes to the previous question, then mention which method motivated you to use? Mention method code\_\_\_\_\_

17. Did the provider tell you about any serious side effects of pills, when you must discontinue them and see a provider immediately? 1. Yes 2. No

18. What were these side effects? Describe \_\_\_\_\_

19. Did the provider counsel you about “dual protection “of condom?

1. Yes 2. No  
3. Only family planning method  
4. Only protection from STI/HIV

20. Did the provider use any of the communication support material given below?	Tick if yes
1.Flip book	
2.Model of contraceptive	
3.Poster	
4.Brochure	
5.Instruction sheet	
6.Other(specify)	

21. Did the provider make you repeat any information to see whether you remembered the detail?

1. Yes 2. No

22. Were you given any informational material to take with you?

1. Yes 2. No

23. What is the general hygienic condition at the facility?

24. Does the health facility have access to running water and working toilets?

Annex 6 Sample Amharic questionnaire for exit interview

ስለ ቤተሰብ ምጣኔ አገልግሎት ጥራት ለማጥናት የተዘጋጀ መጠይቅ

መግቢያና ስምምነት ማረጋገጫ

ጤና ይስጥልኝ ስሜ----- ይባላል። እኔ በአዲስ አበባ ዩኒቨርሲቲ የሀገር ልማት ጥናት ኮሌጅ የስነ ሕዝብ ጥናት ማዕከል ለመመረቂያ በሚደረግ ጥናት የሁለተኛ ዲግሪ ተማሪ ለሆነው ቤካ ጣሰው በመረጃ ሰብሳቢነት እየሠራሁ እገኛለሁ። ይህ ጥናት የሚከሄደው በቤተሰብ ምጣኔ ጥራት ላይ ሲሆን ጥራት ያለው የቤተሰብ ምጣኔ አገልግሎት በጤና ድርጅቶች ከተሰጠ ተጠቃሚዎችን እንደሚጨምር ይታመናል። የዚህ ጥናት ዋና አላማ የጤና ድርጅቶችን የቤተሰብ ምጣኔ አገልግሎት በመገምገም ጠቃሚ መረጃዎችን በመስጠት ለወደፊት ጥራቱን በማሳደግና የቤተሰብ ምጣኔ አገልግሎት ተጠቃሚዎችን ለመጨመር ነው ቃለመጠይቁ በአማካይ ከ30-40 ደቂቃ ይወስዳል። ገዜዎን መስዋት አድረገው ለጥያቄዎች መልስ ለመስጠት ፍቃደኛ ከሆነ ምስጋናችን ከፍተኛ ነው። ስሞ ከዚህ መጠይቅ ላይ አይሞላም። የሚሰጡት መረጃ ሙሉ በሙሉ ሚስጥራቸው ይጠበቃል። በጥናቱ ተሳታፊ ለመሆን የእርስዎ ፍቃደኝነት ያስፈልጋል። በጥናቱ ተሳታፊ ከሆኑ የሚሰጡት እውነተኛ መረጃ የቤተሰብ ምጣኔ አገልግሎቱን ጥራት ለማሻሻል ከፍተኛ አስተዋጽኦ ያደርጋል።

ፈቃደኛ ነዎት ልቀጥል?

ፈቃደኛ ነኝ  ፈቃደኛ አይደለሁም

የቃለ መጠይቅ አድረጊው ስም ----- ፊርማ ----- ቀን -----

ቃለ መጠይቁን ያረጋገጠው ሱፐርቫይዘር ስም ----- ፊርማ -----

የቤተሰብ ምጣኔ ተጠቃሚ መለያ ኮድ

የመኖሪያ አድራሻ ክልል ----- ክልል ከተማ ----- ወረዳ -----

ደንበኛው የጤና ተቋሙ ውስጥ የደረሱበት ሰዓት -----

ደንበኛው አገልግሎት ያገኘበት ሰዓት -----

ጠቅላላ የቆዩበት ሰዓት -----

**ክፍል 1: ማሕበራዊ መረጃዎችን በተመለከተ የሚቀርብ መጠይቅ።**

ተ.ቁ	ጥያቄና ማጣሪያ	የመልስ አማራጭና መለያ ኮድ ቁጥር	ይዘለል
101	እድሜዎ ስንት ነው?	1. እድሜ በዓመት ..... 88. አላውቀውም 99. መልስ አልተሰጠም	
102	ለቤተሰብ ምጣኔ አገልግሎት ሲመጡ ይህ የመጀመሪያ ጊዜዎ ነው?	1. አዎ 2. አይደለም	
103	የጋብቻ ሁኔታ	1.ያላገባች 4. ከባላ የተፋታች 2.ያገባች 5. ባላ የሞተባት 3.ያገባች ግን አብራ ማትኖር	
104	ያገቡ ከሆነ ስለ ቤተሰብ ምጣኔ ከባለቤትዎ ጋር ተነጋግረው ያውቃሉ?	1.አዎ 2. አልተነጋገርኩም 99. አላስታውስም	
105	ልጆች አለዎት?	1. አዎ 2. የለኝም -----	ወደ ጥ.ቁ 110
106	ልጆች ካሉዎት ስንት ልጆች ወልዳዋል?	1. አንድ 2. ሁለት 3. ሶስትና ከዚያ በላይ	
107	ተጨማሪ ልጅ ለመውለድ ይፈልጋሉ?	1. አዎ 2. አልፈልግም 3. እግዚአብሔር ያውቃል 4. ባለቤቴ ያውቃል 99. መልስ አልተሰጠበትም	
108	ተጨማሪ ልጅ ለመውለድ ከፈለጉ መቼ እንዲውልዱ ይፈልጋሉ?	1. አሁኑኑ 2. ከአንድ እስከ ሁለት አመት 3. ከሁለት አመት በኋላ 99. መልስ አልተሰጠበትም	
109	አሁን ጡት ያጠባሉ?	1. አዎ 2. አላጠባም	
110	የትምህርት ደረጃዎ ምን ያህል ነው?	1. ማንበብና መጻፊ የማይችሉ 2. ማንበብና መጻፊ ብቻ 3. አንድኛ ደረጃ የጨረሱ (1-8ኛ) 4. ሁለተኛ ደረጃ የጨረሱ 5. 12 +1 እና በላይ	
111	ሐይማኖትዎ ምንድነው?	1. ኦርቶዶክስ 2. ካቶሊክ 3. ፕሮቴስታንት 4. እስልምና 5. ሌላ/ይገለጹ.....	
112	ብሔራሰብዎ ምንድነው?	1. አማራ 2. ኦሮሞ 3. ጉራጌ 4. ትግራይ 5.ሌላ/ይገለጹ/	

113	ሥራዎ ምንድነው?	<ol style="list-style-type: none"> <li>1. የመንግስት ሠራተኛ</li> <li>2. የግል መሥሪያ ቤት ተቀጣሪ</li> <li>3. ነጋዴ</li> <li>4. ሥራ ፈላጊ</li> <li>5. የቤት እመቤት</li> <li>6. ተማሪ</li> <li>7. የቀን ሠራተኛ</li> <li>8. ገበሬ</li> <li>9. ሌላ/ይገለጽ/.....</li> </ol>	
114	የቤተሰብዎ የወር ገቢ በአማካይ ምን ያህል ነው?	----- ብር	

**ክፍል 2: ተጠቃሚዎች ለአገልግሎቱ ያላቸው ቀረቤታና አቀባበልን በተመለከተ (ለአዲስና ለነባር ተጠቃሚዎች) የሚቀርብ ቃለ መጠይቅ::**

ተ.ቁ	ጥያቄና ማጣሪያ የጤና ድርጅት	የመልስ አማራጭና መለያ ኮድ ቁጥር	ይዘለል
201	ከዚህ የቤተሰብ ምጣኔ አገልግሎት እንደሚሰጥ መጀመሪያ ማን ነገረዎት?	<ol style="list-style-type: none"> <li>1. ባለቤቱ</li> <li>2. ጎረቤቶቼ/ጋደኞቼ</li> <li>3. የጤና ባለሙያ</li> <li>4. ከቴሌቪዥን/ ሬዲዮ/ 5. ሌላ.....</li> </ol>	
202	ከቤትዎ እዚህ ጤና ድርጅት ለመድረስ ምን ያህል ጊዜ ይጨርሱብዎታል?	<ol style="list-style-type: none"> <li>1. ከግማሽ ሰዓት በታች</li> <li>2. ከግማሽ ሰዓት እስከ አንድ ሰዓት</li> <li>3. ከአንድ ሰዓት በላይ</li> </ol>	
203	እዚህ ክሊኒክ ከደረሱበት ሰዓት ጀምሮ አገልግሎት እስከ አገኙበት ምን ያህል ጊዜ ቆዩ?	<ol style="list-style-type: none"> <li>1. ከግማሽ ሰዓት በታች</li> <li>2. ከግማሽ ሰዓት እስከ አንድ ሰዓት</li> <li>3. ከአንድ ሰዓት በላይ</li> </ol>	
204	ለአገልግሎት ስለቆዩበት ጊዜ ምን ይሰማዎታል	<ol style="list-style-type: none"> <li>1. ምንም ቆይታ የለም</li> <li>2. አጭር ጊዜ ነው</li> <li>3. ረጅም ጊዜ ነው</li> <li>4. በጣም ረጅም ጊዜ ነው</li> </ol>	
205	በዛሬው እለት የሚፈልጉትን አገልግሎት አግኝቻለሁ የሚል ስሜት አለዎት?	<ol style="list-style-type: none"> <li>1. አዎ.....</li> <li>2. የለኝም</li> </ol>	ወደ ጥ.ቁ207
206	ካለገኙ ዋና ምክንያት ምን ይመስልዎታል?	<ol style="list-style-type: none"> <li>1. አገልግሎት ሰጭው ፍላጎት ስለሌለው</li> <li>2. የምፈልገው አገልግሎት ባለመኖሩ</li> <li>3. ጊዜው አጭር በመሆኑ</li> <li>4. ሌላ/ይገለጽ/.....</li> </ol>	
207	ከባለሙያው ጋር ለመነጋገር የነበረው ጊዜ አንዴት ያዩታል?	<ol style="list-style-type: none"> <li>1. ጊዜው በቂ ነበር 88. አላውቅም</li> <li>2. በጣም አጭር ነበር 99. መልስ አልተሰጠም</li> <li>3. በጣም ረጅም ነበር</li> </ol>	

208	በምክር አገልግሎት ጊዜ የምክር አገልግሎት ሰጭውን በቀላሉ መረዳት ይቻላል?	1. በቀላሉ መረዳት ይቻላል 2. ለመረዳት በጣም አስቸጋሪ ነበር 3. መረዳት አይቻልም 99. መልስ አልተሰጠበትም	
209	ለብቻዎ የተሰጠዎት የምክር አገልግሎት ሁኔታው እንዴት ነበር?	1. በቂና አመቺ ነበር 2. በቂ አልነበርም 99. መልስ አልተሰጠበትም	
210	የቤተሰብ ምጣኔ አገልግሎት የሚሰጠበት ሌላ ጤና ድርጅት ያውቃሉ?	1. አዎ 2. የለውቅም	
211	የሚያውቁ ከሆነ ለቤትዎ ቅርብ ነው/ ለዚህ ጤና ድርጅት ይቀርባል?	1. አዎ/ይቀርባል/ 2. አይቀርብ 88. አላውቅም 99. መልስ አልተሰጠበትም	

**ክፍል 3. ንዑስ ክፍል 1: ለአዲስ ቤተሰብ ምጣኔ አገልግሎት ተጠቃሚዎች የሚቀርብ መጠይቅ::**

ተ.ቁ	ጥያቄና ማጣሪያ	የመልስ አማራጭና መለያ ኮድ ቁጥር	ይዘለል
212	ወደዚህ ጤና ድርጅት ለምን መጡ?	1. የወሊድ መቆጣጠሪያ ለመውሰድ 2. የምክር አገልግሎት ለማግኘት ብቻ 3. ሁለቱንም አገልግሎት ለማግኘት 99. መልስ አልተሰጠም	
213	አሁን የወሊድ መቆጣጠሪያ ለመውሰድ ወስነዋል?	1. አዎ 2. አልወሰንኩም ..... 99. መልስ አልተሰጠም	ወደ ተ.ቁ 215
214	መልሱ አዎ ከሆነ የትኛውን ዘዴ ነው የመረጡት?	1. ክኒን 2. በማሕፀን የሚቀመጥ 3. ኮንዶም 4. ማሕፀን ቆብ 5. በመርፌ መልክ የሚሰጠውን 6. ማፀሕን ማስቋጠር 7. ፀረ ወንድ ዘር ፍሬ (ፈሳሽ ቅባት) 8. በክንድ ላይ ሚቀበር 9. ሌላ (ይገለጽ)	
215	መልሱ አልወሰንኩም ከሆነ ለምን የወሊድ መከላከያ ዘዴ መጠቀም አልፈለጉም?	1. ሃሳቤን በመቀየሪያ 2. መረጃ ብቻ ለማግኘት ስለመጣሁ 3. እርግዝና ጥርጣሬ ስላለ 4. የምፈልገው የወሊድ መቆጣጠሪያ ዘዴ እኔ ልወስደው የማልችል መሆኑ ስለ ተነገረኝ 5. የፈለኩት የመከላከያ ዘዴ ስላሌላ 88. አላውቅም 99. መልስ አልተሰጠበትም	

216	እርስዎ ስለሚወስዱት የወሊድ መከላከያ ዘዴ የምክር አገልግሎት ስጪው ስለሚከተሉት ነጥቦች በቂ ገለጻ አደረገለዎት?		
216.1	የወሊድ መከላከያ ዘዴው እንዴት እንደሚሰራ ነገረዎት?	1. አዎ 2. አልተነገረኝም 99. መልስ አልተሰጠበትም	
216.2	እንዴት እንደሚጠቀሙ አሳይቶታል?	1. አዎ 2. አልተነገረኝም 99. መልስ አልተሰጠበትም	
216.3	ስለሚያመጣው ጠንቅ ተነግሮዎታል?	1. አዎ 2. አልተነገረኝም 99. መልስ አልተሰጠበትም	
216.4	ችግር ቢያጋጥምዎ የቀጠሮዎ ቀን ከመድረሱ በፊት መምጣት እንዳለብዎት ተነግሮዎታል?	1. አዎ 2. አልተነገረኝም 99. መልስ አልተሰጠበትም	
216.5	የመከላከያ ዘዴው ካልተስማማዎት ሊቀይሩ እንደሚችሉ ተነግሮዎታል?	1. አዎ 2. አልተነገረኝም 99. መልስ አልተሰጠበትም	
216.6	የመከላከያ ዘዴው ካልተስማማዎት ሊቀይሩ እንደሚችሉ ተነግሮዎታል?	1. አዎ 2. አልተነገረኝም 99. መልስ አልተሰጠበትም	
217	አሁን ሊጠቀሙበት ከተቀበሉት የወሊድ መከላከያ ሌላ የወሊድ መከላከያ ዘዴ እንዳለ ተነግሮዎታል?	1. አዎ 2. አልተነገረኝም 99. መልስ አልተሰጠበትም	
218	መልስዎ አዎ ከሆነ የትኛውን የመከላከያ ዘዴ?		
218.1	ክኒን	1. አዎ 2. አይደለም	
218.2	በመርፌ መልክ የሚሰጠውን	1. አዎ 2. አይደለም	
218.3	ፀረ ወንድ ዘር ፍሬ (ፈሳሽ ቅባት)	1. አዎ 2. አይደለም	
218.4	የማሕፀን ቆብ	1. አዎ 2. አይደለም	
218.5	በማህፀን የሚቀመጥ	1. አዎ 2. አይደለም	
218.6	ኮንዶም	1. አዎ 2. አይደለም	
218.7	ማህፀን ማስቋጠር	1. አዎ 2. አይደለም	
218.8	በክንድ ላይ የሚቀበር	1. አዎ 2. አይደለም	
218.9	ሌላ/ይገለጹ.....	1. አዎ 2. አይደለም	
219.	ከወሊድ መከላከያ ዘዴ ተጨማሪ ሌላ አገልግሎት አግኝተው ነበር?	1. አዎ 2. አይደለም	
219.1	መልሱ አዎ ከሆነ የትኛውን አገልግሎት አግኝተዋል?	1. ውርጃ 2. የአባልዘር በሽታ 3. ክትባት 4. ድህረ ወሊድ ክትትል 5. ሌላ/ይገለጹ.....	

**ክፈል 3. ንዑስ ክፍል 2፡ ለተመላላሽ ቤተሰብ ምጣኔ አገልግሎት ተጠቃሚዎች የሚቀርብ መጠይቅ፡**

ተ.ቁ	ጥያቄና ማጣሪያ የጤና ድርጅት	የመልስ አማራጭና መለያ ኮድ ቁጥር	ይዘለል
220	የትኛውን የመከላከያ ዘዴ ነው የሚጠቀሙት?	<ol style="list-style-type: none"> <li>1. ክኒን</li> <li>2. በመርፌ መልክ የሚሰጠውን</li> <li>3. ፀረ ወንድ ዘር ፍሬ (ፈሳሽ ቅባት)</li> <li>4. ማሕፀን ቆብ</li> <li>5. በማሕፀን የሚቀመጥ</li> <li>6. ኮንዶም</li> <li>7. በክንድ ላይ የሚቀበር</li> <li>8. ሌላ (ይገለጽ).....</li> </ol>	
221	አሁን ከሚጠቀሙበት የወሊድ መከላከያ ሌላ የትኛውን ዘዴ ያውቃሉ?		
221.1	1. ክኒን	1. አዎ 2. አይደለም	
221.2	2. በመርፌ መልክ የሚሰጠውን	1. አዎ 2. አይደለም	
221.3	3. ፀረ ወንድ ዘር ፍሬ (ፈሳሽ ቅባት)	1. አዎ 2. አይደለም	
221.4	4. ማሕፀን ቆብ	1. አዎ 2. አይደለም	
221.5	5. በማሕፀን የሚቀመጥ	1. አዎ 2. አይደለም	
221.6	6. ኮንዶም	1. አዎ 2. አይደለም	
221.7	7. በማፀሕን ማስቋጠር	1. አዎ 2. አይደለም	
221.8	8. በክንድ ላይ የሚቀበር 9. ሌላ .....	1. አዎ 2. አይደለም	
222	ባለፈው ይጠቀሙበት የነበረውን የወሊድ መከላከያ ዘዴ ከዚህ የጤና ድርጅት ነበር የተጠቀሙት?	1. አዎ 2. አይደለም	
223.	ከዚህ ካልሆነ ከየት ነበር የሚያገኙት?	<ol style="list-style-type: none"> <li>1. ከሌላ የመንግስት ጤና ድርጅት</li> <li>2. ከግል ክሊኒክ</li> <li>3. የመንግስታዊ ያልሆኑ ጤና ድርጅት</li> <li>4. መድሀኒት ቤት</li> <li>5. ሌላ/ይገለጽ/</li> </ol>	
224.	የወሊድ መከላከያ ዘዴውና ለአገልግሎቱ ክፍለዋል?	1. አዎ 2. አይደለም	
225.	የክፍሉ ከሆነ ለአንድ ጉብኝት ምን ያህል ክፍሉ?	<ol style="list-style-type: none"> <li>1. ለወሊድ መቆጣጣሪያ ብር -----</li> <li>2. ለአገልግሎት ብር -----</li> </ol>	
226	የእርስዎ ንደኛ የወሊድ መከላከያ ዘዴ ለመውሰድ ቢፈለጉ ወደዚህ ጤና ድርጅት እንዲመጡ ይገፋፋችዋል?	<ol style="list-style-type: none"> <li>1. እዚህ ክሊኒክ እንዲመጡ እገፋፋለሁ</li> <li>2. ሌላ ቦታ እንዲሄዱ እመክራለሁ</li> <li>88. አላውቅም</li> <li>99. መልስ አልተስጠኝም</li> </ol>	
227.1	ወደ ሌላ ጤና ድርጅት እንዲሄዱ ከገፋፋ		

	ለምን?		
227.2	ረጅም ጊዜ ስለሚያቆዩ	1. አዎ 2. አይደለም	
227.3	ሩቅ በመሆኑ	1. አዎ 2. አይደለም	
227.4	ጥራት ያለው አገልግሎት እዚህ ስለሌለ	1. አዎ 2. አይደለም	
227.5	የሚሰጠው የምክር አገልግሎት ደካማና በቂ ስላልሆነ	1. አዎ 2. አይደለም	
227.6	ሌላ/ይገለጽ		
228.	ከዚህ የጤና ተቋም የትኛውን አገልግሎት ወደውታል?		
228.1	አገልግሎቱ በአጭር ጊዜ ውስጥ ነው የሚያገኙት	1. አዎ 2. አይደለም	
228.2	አገልግሎት ሰጪው ጥሩ አገልግሎት ይሰጣል	1. አዎ 2. አይደለም	
228.3	የምክር አገልግሎት ግልጽና አጥጋቢ ነው	1. አዎ 2. አይደለም	
228.4	የመረጡትን የመከላከያ ዘዴ ነው የተጠቀሙት	1. አዎ 2. አይደለም	
228.5	ሌላ/ይገለጽ		
228.6	መልስ አልተሰጠም		

**ክፍል 4 በተለየ ወሊድ መከላከያ ዘዴዎች ላይ ያተኮሩ የእውቀት ጥያቄዎች/ለአዲስና ለተመላላሽ ተጠቃሚዎች**

**ለክረን ተጠቃሚዎች**

229	ክረን መወሰድ መች ነው መጀመር ያለበት?	1. የወር አበባ በመጣ ከ 1-5 ቀን ውስጥ 2. በማንኛውም ሰዓት 3. አላውቅም 4. መልስ አልተሰጠም	
230	የወሊድ መከላከያ ክረን በምን ያህል ጊዜ ልዩነት መወሰድ አለበት?	1. አንድ ክረን በቀን በተመሳሳይ ሰዓት 2. በማንኛውም ሰዓት 3. በግብረ ስጋ ግንኙነት ጊዜ 88. አላውቅም 99. መልስ አልተሰጠም	
231.	የወሊድ መከላከያ ክረን በሚወስድበት ጊዜ ምን ዓይነት ቀለል ያሉ ችግሮችን ሲከስቱ ይችላሉ?		
231.1	ችግር አይኖርም	1. አዎ 2. አይደለም	
231.2	ቀላል ራስ ምታት	1. አዎ 2. አይደለም	
231.3	መጠነኛ ክብደት መጨመር	1. አዎ 2. አይደለም	
231.4	ማቅለሽለሽ	1. አዎ 2. አይደለም	
231.5	ያልተጠበቀ የደም ጠብታ በብልት መፍሰስ	1. አዎ 2. አይደለም	
231.6	ሌላ/ይገለጽ/		
231.7	አላውቅም	1. አዎ 2. አይደለም	

**በመርፌ መልክ የወሊድ መከላከያ ለሚወስድ**

ተ.ቁ	ጥያቄና ማጣሪያ	የመልስ አማራጭና መለያ ኮድ ቁጥር	ይዘለል
232	በመርፌ መልክ የሚወስዱት የወሊድ መቆጣጠሪያ ጥቅም ተነግሮታል?	1. አዎ 2. አላውቅም	
233	በመርፌ መልክ የሚወስዱት የወሊድ መቆጣጠሪያ በየስንት ጊዜው ነው መወስድ የለበት?	1. በየወሩ 2. በየ ሰዓት ወሩ 3. በየዓመቱ 88. አላውቅም	
234	የወሊድ መከላከያ በመርፌ መልክ በሚወስዱበት ጊዜ ከመደበኛ ቀጠሮ ውጭ ምን አይነት ችግር ቢከሰት ነው ወደ ጤና ድርጅት ሊመለሱ የሚችሉ?		
234.1	ችግር አይኖርም	1. አዎ 2. አይደለም	
234.2	ከባድ ራስ ምታት	1. አዎ 2. አይደለም	
234.3	ከብልት ብዛት ያለው ደም መፍሰስ	1. አዎ 2. አይደለም	
234.4	ሌላ/ ይገለጽ		
234.5	አላውቅም		

**በማሕፀን ውስጥ ለሚቀመጥ መከላከያ ለሚወስዱ**

ተ.ቁ	ጥያቄና ማጣሪያ የጤና ድርጅት	የመልስ አማራጭና መለያ ኮድ ቁጥር	ይዘለል
235	በማሕፀን ውስጥ የተመጠልዎት የወሊድ መከላከያ በቦታው መኖሩን እንዴት ነው የሚያረጋግጡት?	1. በብልት ውስጥ ክሮች መኖራቸውን በየጊዜው በመዳሰስ 2. አንድ ጊዜ በማሕፀን ከተቀመጠ ከዚያ በኋላ አይወጣም 88. አላውቅም	
236	በማሕፀን ውስጥ ለተቀመጠዎት የወሊድ መከላከያ ለመጀመሪያ ጉብኝት መቻሉን እንዲመጡ ተቀጠሩ ?	1. መመለስ ወይም ቀጠሮ አያስፈልግም 2. ከአንድ ወር ባነሰ ጊዜ ውስጥ 3. ከወር በኋላ 4. ከአመት በኋላ 5. 88. አላውቅም	
237	በማሕፀን ውስጥ የሚቀመጥ የወሊድ መከላከያ ከተቀመጠዎት በኋላ ምን አይነት ቀለል ያሉ ችግሮች ሊኖርዎት ይችላሉ?		

237.1	ችግር አይኖርም	1. አዎ 2. አይደለም	
237.2	ያልተጠበቀ የደም ጠብታ በብልት መፍሰስ	1. አዎ 2. አይደለም	
237.3	ከብልት ላይ መጠነኛና ያልተለመደ ፈሳሽ መጨመር	1. አዎ 2. አይደለም	
237.4	ብክለት/ህመም	1. አዎ 3. አይደለም	
237.5	ሌላ/ይገለጽ		
237.6	አላውቅም		
238	በማሕፀንዎ ውስጥ የሚቀመጥ የወሊድ መከላከያ ለምን ያህል ጊዜ እርግዝናን ይከላከላል?	1. ለ12 አመት 2. ለ5 አመት 3. ለ3 አመት 88. አላውቅም	

**በክንድ ላይ የሚቀበር የወሊድ መከላከያ ለሚወስዱ**

ተ.ቁ	ጥያቄና ማጣሪያ የጤና ድርጅት	የመልስ አማራጭና መለያ ኮድ ቁጥር	ይዘለል
239	በክንድ ላይ የሚቀበረው የወሊድ መከላከያ በስንት ጊዜ መቀየር አለበት?	1. በየ አምስት አመት 2. በየ ሁለት አመት 3. በየ ሶስት አመት 4. በየ አራት አመት 88. አላስታውስም	
240	በክንድ ላይ የሚቀበረው የወሊድ መከላከያ ዘዴ ጥቅም ተነግሮዎታል?	1. አዎ 2. አልነገረኝም	
241	በክንድ ላይ የሚቀበረው የወሊድ መከላከያ ከመደበኛ ቀጠሮዎ ውጭ ምን አይነት ችግር ቢከሰት ነው ወደ ጤና ድርጅት ሊመለሱ የሚችሉ?		
241.1	ችግር አይኖርም	1. አዎ 2. አይደለም	
241.2	ከፍተኛ እራስ ምታት	1. አዎ 2. አይደለም	
241.3	ብዛት ያለው ደም ሰብክት	1. አዎ 2. አይደለም	
241.4	ክብደት መጨመር	1. አዎ 2. አይደለም	
241.5	ሌላ/ይገለጽ		
241.6	አላውቅም		

5. አጠቃላይ የደንበኛ እርካታን መለኪያ/ ለአዲስ ተመላላሽ ደንበኛ/

ተ.ቁ	ጥያቄና ማጣሪያ የጤና ድርጅት	የመልስ አማራጭና መለያ ኮድ ቁጥር	ይዘለል
242	የወሊድ መከላከያ ዘዴው እንዴት እንደሚሰራ በግልጽ ተነገሮት	1. አዎ 2. አይደለም	
243	አገልግሎት ሰጭው ለሚሰራቸው ሥራዎች ጥሩ እውቀትና ችሎታ አለው?	3. አዎ 4. አይደለም	
244	አገልግሎቱ ሲሰጠው ጥሩና የንግድነት ስሜት ነበር?/ ደህና አደርሻ ወይም ደህና ዋልሽ በማለት ሰላምታ ስጠተዎታል?	1. አዎ 2. አይደለም	
245	በምክር አገልግት ጊዜ ለብቻዎና አመች ሁኔታ ተፈጥሮዎት ነበር? ሌላ ተገልጋይ እርስዎ የሚያወሩትን አይሰማም/አያይም	1. አዎ 2. አይደለም	
246	ለቤተሰብ ምጣኔ አገልግሎት ሰጭው ጥያቄና ማብራሪያ የማቅረብ ዕድል አግኝተው ነበር?	1. አዎ 2. አይደለም	
247	በቂ የወሊድ መከላከያ ዘዴዎች ነበሩ	1. አዎ 2. አይደለም	
248	አገልግሎት ሰጭው ለሚቀጥለው ቀጠሮዎ የመመለሻ ቀን ሰጥቶዎታል?	1. አዎ 2. አይደለም	
249	አገልግሎቱ የሚሰጥበት ክፍል ንፅህናው የተጠበቀ ነው?	1. አዎ 2. አይደለም	
250	አገልግሎት እስኪያገኙ የቆዩበት ቦታ ለፀሃይና ለዝናብ አልተጋለጠም	1. አዎ 2. አይደለም	
251	በሌሎች የድርጅቱ ሰራተኞች የተደረገሎት አቀባበል ጥሩና የንግድነት ስሜት ነበረው	1. አዎ 2. አይደለም	
252	አገልግሎቱን እስኪያገኙ በተቋሙ የቆዩበት ሰዓት በቂ ነበር	1. አዎ 2. አይደለም	
	አጠቃላይ ድምር		

**Assurance of Principal Investigator**

The undersigned agrees to accept responsibility for the scientific ethical and technical conduct of the research project and for provision of required progress reports as per terms and conditions of the research publications office in effect at the time of grant is forwarded as the result of this application.

Name of the student: **Becka Tasew**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Approval of the Advisor**

Name of the Advisor: **Dr. Assefa Hailemariam**

Signature; \_\_\_\_\_

Date: \_\_\_\_\_