ASSESSMENT OF STATUS OF LONG ACTING AND PERMANENT FAMILY PLANNING SERVICES IN MEKELLE TOWN, TIGRAY REGIONAL STATE

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ACRONYMS

AIDS	Acquired immuno Deficiency Syndrome
CBD	Community based distribution
DHS	Demographic and Health Surveys
FP	Family planning
GFR	General Fertility rate
IEC	Information Education and Communication
IUCD	Intra utérine contraceptive devise
LAPM	Long acting and permanent contraceptive methods
MDG	Millennium Development Goal
MMR	Maternal mortality ratio
MMR	Maternal mortality Rate
MOH	Ministry of health
PID	Pelvic inflammatory disease
PNA	Performance needs assessment
SDP	Service Delivery Points
TFR	Total fertility rate
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Abstract

Despite the reality of a high unmet need, Contraceptive prevalence in the country is very low with only 15% of married women using any type of contraception. Besides to this, the knowledge and practice of family planning is limited to the usage of short- term contraceptive methods. So the objective of this study is to assess the status of long acting and permanent family planning services provision. A cross-sectional descriptive study that involved exit interviews with clients, health care providers, observations on clients-provider interactions, assessment of the availability of necessary resources for provision of LAPMs, and service statistics review was conducted from April to June 2008 in six health service delivery points in Tigray regional state of Mekelle town. Four hundred twenty two FP clients and ten health care providers were interviewed while observation on 481 client-health care provider interactions was conducted. About 269(92.4%) clients wanted their next birth after two to six years. currently 392(92.9%) and 30(7.1%) of clients are using injectable and pill respectively. Of the total clients 312 (73.9%) and 99(23.5%) were using the method for spacing and limiting respectively. About 10(20.4%), 3 (6.1%), 2 (4%) and 1 (2%) of new clients were informed about implants, IUCD, and female and male sterilization respectively. about 183(87.6%) of the clients stated the provider let them ask the questions and among these 175(95.6%) the providers responded to their questions satisfactorily. Of the 10 health care providers interviewed six had received training in counseling and providing implants with in the last five years. Four of the providers did not feel that they had knowledge and skills necessary to do LAPM services. Four and five facilities reported running out of pills and implants in last six months respectively. Several constraints in the provision of LAPM service are identified and needs to be improving through training, coordination and maintaining adequate resources.

1. INTRODUCTION

1.1 Overview

Four contraceptive methods are categorized as long-acting or permanent (LAPM) methods these are: intrauterine devices (IUDs), implants, female sterilization, and vasectomy. IUDs and implants are long-acting temporary methods; when removed, return to fertility is prompt. Copper-containing IUDs, the ones generally available in African family planning programs, are effective for at least 12 years, although they are labeled for 10 years. It has some side effects: increased risk of PID, pain, perforation and bleeding. Implants, depending on the type, last for up to three to seven years with disadvantages of spotting, dizzness, weight gain and so on…. Female sterilization, or tubal ligation, and vasectomy are permanent methods that need couples commitment and decision because that may end with divorce [1].

Ethiopia is one of the countries with the highest maternal mortality, which is estimated at 670 per 100,000 live births which is more than one in five deaths to women age 15-49 [2]. The major causes of maternal mortality and suffering are unsafe abortion, obstructed labor, sepsis, hemorrhage, pregnancy induced hypertension and others [3]. With an estimated current population of over 77.4 million people which is the second most populous country in Africa next to Nigeria. The population is growing at a rate of 2.7 percent annually [4]. Contraceptive prevalence in the country is very low with only 15% of married women using any type of contraception almost all of these users are using

modern methods. The most widely used method is injectables (10 percent) followed by the pill (3 percent) and the unmet need for spacing is 22 percent, while the unmet need for limiting is 14 percent. Thus, the total unmet need is 36 percent [2] this eventually leads to large numbers of unwanted pregnancies every year. This, together with the high level of fertility 5.4 births per women and a low level of contraceptive use, suggests that the population will continue to grow at a fast pace for at least another generation. At the current rate, the population size will double within 23 years [5]. Twenty eight percent of mothers received antenatal care from health professionals for their most recent birth and only 6 percent of births were delivered with the assistance of a trained health professional, the total fertility rate for Ethiopia is 5.4 births per woman. The TFR in the rural areas is 6.0, two and half times higher than the TFR in the urban areas (2, 4). As expected; fertility is considerably higher in the rural than urban areas. This is a significant achievement from 5.9 in 2000 but the current rate still remains high [2].

Delivery of family planning services is one of the most important strategies for reducing maternal morbidity and mortality worldwide [6]. Couples and individuals currently use either modern or traditional methods to space or permanently stop having children. Contraceptive method mix usage differs from program to program and region to region based on the availability of the methods, affordability of the services and other barriers such as socio-cultural factors. Generally, contraceptive users in Africa rely on shorter-term methods such as

pills, while the usage of long and permanent methods is more common in Asia and Latin America [7, 9]. All modern methods which provide a wide range of protection from durations of as short as days (pills, injectables, condoms and other barrier methods) to permanent protection such as voluntary surgical sterilization, implants, intra uterine device, are available in Ethiopia. However, utilization is limited very much to the shorter-term methods such as pills and injectables as the EDHS 2005 method mix shows [IUD 0.2 %, PILL 3 %, VSC 0.2%, IMPLANTS 0.2 %, INJECTABLE 10 %]. The majority of Ethiopian women (78 percent) and men (76 percent) prefer to space or limit the number of children they have, and have a potential need for family planning. One in three currently married women has an unmet need for family planning If all currently married women who say they want to space or limit the number of children were to use family planning, the contraceptive prevalence rate in Ethiopia would increase from 15 percent to 49 percent. Currently, only 31 percent of the demand for family planning is being met [2, 4].

1.2. Rationale of the study

Long-acting and permanent methods are by far the most effective (99 percent or greater) methods of contraception available and are very safe and convenient. Only one action by client and provider results in years of protection against unintended pregnancy. While the LAPM offers so many comparative advantages with the above mentioned side effects for women in countries such as Ethiopia why is it not more widely used? So the goal of the study was to assess status of long acting and permanent family planning method services. Given the lack of

understanding of the reasons why LAPM use in Ethiopia has stagnated and may have declined, the study addressed the following key questions:

- What client characteristics affect the demand for and use of LAPM?
- What are the provider and system characteristics that shape provision of the LAPM?

2. LITERATURE REVIEW.

Ensuring LAPM methods are available is important to meeting people's needs. Experience in countries where LA/P methods are available shows that they are highly popular:

- Female sterilization is the most widely used method of contraception worldwide, accounting for approximately 20 percent of all contraception.
- The second most popular method is the IUD, used by 150 million women.
- Vasectomy is the fourth most popular method, after oral contraceptives, and is simpler and safer than female sterilization.

One reason these methods are so popular is that they are highly effective; another is that they do not require daily use or repeated visits to obtain resupply [1]. Almost all women are eligible for IUDs, implants, and/or sterilization and all men who do not want more children are eligible for vasectomy. Of course, permanent methods are only appropriate for couples who have achieved their desired family size [11]. Long-acting and permanent methods are by far the most effective (99 percent or greater) methods of contraception available and are very safe and convenient with some side effects. They are all clinical methods and thus must be provided by trained doctors, nurses, and/or midwives in health

facilities. Only one action by client and provider results in years of protection against unintended pregnancy. The desirability of these methods is due to their long life span, which requires fewer visits to health providers, thus saving clients time, effort, and money while at the same time easing the patient load at health facilities. When available, LAPMs of contraception are chosen by hundreds of thousands of Africans, especially when cost and other access barriers are removed [1]. Although developing countries have made much progress in expanding the availability and use of family planning services, the need for effective contraception in general (and long-acting and permanent methods in particular) is large and growing. Despite the other compelling challenges faced by the international health community, the need to make family planning services more widely available is pressing and should remain a priority [12]. As the report of the International Conference on Population and Development issued the following directive: “Recognize that appropriate methods for couples and individuals vary according to their age, parity, family size preference and other factors, and ensure that women and men have information and access to the possible range of safe and effective family planning methods in order to enable them to exercise free and informed choice [13].

Substantial evidence indicates that a restricted choice of contraceptive methods has constrained the opportunity of individual couples to obtain a method that suits their needs, resulting in lower levels of contraceptive prevalence. One study noted that in Taiwan, each new method seemed to add another layer of use to existing prevalence; similar increases were evident in South Korea,

Thailand and Hong Kong [14]. Broadening the choice of contraceptive methods increased overall contraceptive prevalence in Matlab, Bangladesh, is where household provision of long term and permanent contraceptive methods [15]. In Ghana hospitals and health centers have shown supply problems over time for each method of contraception. Moreover, an average of one in five observed and interviewed clients reported that during the current visit they did not receive information on at least one of the major points queried (how to use their method, what the side effects are, or what to do for problems) [16]. Even though both access to and use of temporary family planning methods (the pill, injectables, and condoms) have increased in recent years, long-acting and permanent methods of family planning (LAPMs), such as male and female sterilization, implants and the intrauterine device (IUD), continue to be underutilized (LAPMs prevalence, 0.5%) in Guinea [17]. In Iran Sterilization (mostly female) accounts for nearly half of all contraceptive use, Other modern methods (mostly IUDs and the pill) account for most of the remainder, while only 9 percent of women rely on traditional methods. This mix of methods has changed only modestly over time. Since 1980, the population growth hits,4.4%, that country's leadership had crossed a thresh hold recognizing that their record population growth was burdening the economy, destroying the environment…, to tackle this what they did was:

- Government mobilized the ministry of education, culture, need to decrease population growth.
- Broadcasting released information encouraging smaller family size

- Religion leaders mobilized to convince couples
- National literacy rate increment and all contraceptive are free of charge, couples must take two days course in family planning in order to get marriage license.

Iran was the first Muslim country to offer male sterilization. For that the proportion of users relying on sterilization and injectables, implants (a new method) has increased, and the pill, IUD, and other methods have become correspondingly less prevalent. All those strategies brought a drop in average family size from seven to less than three [7].

In Tunisia a strong population and social development policy put in place well before the experimental stage of the national FP program in 1964 was important in providing the underpinnings and preparing the public for FP. The introduction of new contraceptive technologies, especially IUCD, oral contraceptive, and abortion were notable. The beginnings were halting and mistakes were made. But the program received strong political support at the highest levels and made corrections over the years. as a result over 40 years Tunisia's CPR has increased from less than 10 % to more than 60%, the total fertility rate has decreased from 6 births per women to two, or below replacement level, and the population growth rate has declined from 2.8% to1.1% .as the new FP program expanded steadily, important changes in socity had a major impact on fertility and acceptance of FP including:

1. Increase in age of marriage
2. Prohibiting polygamy and giving women full legal divorce rights

3. Removing barriers to the importation and sale of contraceptives and the provision of information on contraceptives.
4. Legalizing abortion for personal reasons after the fifth child.
5. Encouraging literacy, especially female literacy.
6. Legalizing female sterilization.

Tunisia's remarkable success and creativity in relation to both population and development policy and FP implementation has set an important example to other countries in the region and throughout the world (8). Women clearly understand the long-term advantages of the IUD and anecdotal evidence shows that many women that had thought, but were not absolutely sure, about undergoing sterilization preferred the IUD to a permanent method. The predicted probability of using injectables increased considerably whereas the probability of using the IUD or implants, and to some extent the pill, declined over this period. This finding suggests that Kenyan women who previously would have used other reversible modern contraceptive methods are now choosing injectables [18].

In Ghana Giving Training and certify nurse auxiliaries and professional nurses in providing LAPMs service at health center and health post strategy, successes was due to careful training in- class and in-service and close follow-up, collaboration with district level workers and MOH officials, well designed training materials, and adequate supervision. To extend LAPMs training nationwide, it is necessary to maintain these high training and supervision standards [19]. The study conducted in Tanzania shows that training and improving problem solving skill of providers improved quality of care in family planning services. As study

conducted in Jimma zone that the providers with and with out special training on family planning service provision have statistically significant different on quality of care, showing providers with training were found to be better than providers with out the training (20, 21).

Expansion of current community-based programs may be the most effective way in the short term of meeting the huge potential demand for contraceptive services in rural Pakistan and in facilitating fertility decline. The deployment of thousands of salaried workers is not a cheap option, nor should the difficulties of maintaining adequate logistical and supervisory systems be understated [22].The quality and quantity of contact between public sector health and family planning workers and rural women also play a major role in contraceptive decision making [23].

The policy variables most closely associated with expanded contraceptive use are men's and, especially, women's education, family planning IEC, and the presence of a CBD worker in the community [24]. In Tanzania although contraceptives were provided free of charge in government facilities and knowledge of contraceptive use was widespread, use was very low and the discontinuation rate was high, Interventions on demand-side and supply-side factors would result in increased modern contraceptive use. Different interventions are required for rural and urban women Policies to raise female schooling and literacy would result in greater contraceptive use in urban and rural Tanzania. A decrease in the average distance to the facility would increase contraceptive use, but at a high cost. Giving women enough information would

also result in increased contraceptive use. Policies should aim at having enough providers at the facility so that they could have enough time to run the education sessions. Display of information about family planning use at the facilities was also important to women's contraceptive use [25].

Contraceptives utilization depends on ready access to multiple methods; a clear mandate exists for Full choice among a variety of contraceptive offerings is yet to be attained in many countries. Its absence restricts personal access to each method as well as the use of all methods in the population. [15]. Kenya has been a leader in family planning (FP) in Africa. It was the first Sub-Saharan African country to adopt a national FP program. Yet, there is still a large unmet need for FP, and long-acting and permanent methods are underutilized. While the percentage of Kenyan women using any modern method has more than tripled in the past 20 years, the IUD has virtually disappeared from the mix of modern FP methods [26].

Health care Providers have good attitudes regarding LAPMs and in particular appreciate the IUD. However, they are not given clear expectations regarding their performance in providing information about LAPMs. Also, information, education, and communication (IEC) materials such as flipcharts (which are used to discuss family planning with clients) tend to provide more information on temporary methods. The environment in which providers work is not always conducive to helping them perform well: Most reported shortages of electricity and water and stock-outs of necessary supplies and materials [17]. There are

numerous quality issues that affect provision of these services in Uganda and other parts of Africa:

- The services availability and supply stocks.
- the quality of provider and interaction (information provision and counseling) with clients,
    - providers' knowledge and understanding of the methods and procedures,
    - provider's ability to avail information on range of contraceptive choices and skill in fully explaining about the methods to clients
    - staff competence in performing the procedures,
    - general staff support for and ownership of the services
- Print materials and other sources of information

Also Promotion of the use of long acting and permanent methods would be most successful in the central districts of Uganda where support exists already but would have to have a different starting and selling point in rural areas and districts outside the central region where support and practices are poor [27]. The usage of wide range of contraceptive method mix improves the quality of family planning services rendered to the community and ensures sustainability of the services. A coordinated effort among facility based and community based providers can assist in ensuring client choices and improving the method mix [28]. Various explanations have been given as to why utilization of the full range of methods is not high. Some focus on factors that hinder the supply of methods

through the service delivery system while others emphasize on factors that influence client demand. Few efforts, however, have taken a closer look at the actual range of methods itself to determine whether it is, in fact, truly appropriate within the Ethiopian context. In other words, rather than assuming that more methods invariably lead to greater contraceptive choice, what is needed is some determination as to what would constitute an appropriate range of contraceptive methods given users' needs, the existing capacity of the public sector health care system and available methods [29]. The study in north Gonder shows that most commonly used family planning methods were injectable 74.4%, pill 20 % and a study in Jimma zone also show 55.9% use injectable and 43.3% use pill. This clearly indicates substantial proportion of clients did not use long acting and permanent contraceptive family planning methods because the injectable and pills were the most commonly discussed methods to new clients and no discussion was made concerning long acting and permanent methods of contraception (20, 30). 37% clients in Ecuador and 65.7% in Jimma zone were not asked their reproductive intentions before initiation of contraceptive methods. How ever it was very helpful for the appropriate choice of method and it could have helped to avoid the dissatisfaction of some clients for whom their choice was not provided (31, 32). And a study conducted in north Gonder shows 99% of clients were not informed about HIV/AIDS and STI with their prevention. Thus in Ethiopia, which is one of hardest hit countries by HIV/AIDS in the world and the third in the number of HIV, infected people in sub-Saharan Africa. This is missed opportunity for HIV/AIDS prevention and controls that needs consideration on FP

clients during counseling sessions (30, 33). The study conducted in Bangladesh showed that the average waiting time for family planning was 30 minutes and the proportion of clients who expressed dissatisfaction was 28.2% which is one of the factors affecting the quality (34). Inadequate or stock-outs of supplies makes the range of method mix minimized in the service delivery points. The fall in the levels of use may also have been caused by significant changes at service delivery points such as staff transfers, or quality-related shortcomings as has been found by numerous studies in East and Southern Africa including Kenya, Botswana, Zimbabwe and Malawi (32, 34).

3. OBJECTIVE

General objective

- To assess current status of long acting and permanent contraceptive family planning method services in health facilities of Mekelle town.

Specific objective

- To assess providers' and clients' attitude/ knowledge towards LAPMs.
- To assess the content of information exchange between the provider and client on the use of LAPM during counseling on method choices.
- To identify provider and other system barriers including in-service training, logistics, availability of LAPM related service, supply/equipment and other issues that may restrict clients' access to the use of LAPM.

4. METHODOLOGY

4.1 Study Design and Study Area

This facility based cross sectional descriptive survey was conducted in Tigray Regional State in Mekelle town, located 776 kms north from Addis Ababa. The population of Tigray regional state is 4.6 million; Mekelle has a population of 215,760. As to the health facilities the region consist 16 Hospitals (both private and governmental), 42 Health centers, and 529 Health posts. In Mekelle there are two hospitals, three health centers and two nucleus health centers making the health service coverage 56%, with the contraceptive prevalence rate of 38.2%.

This facility based cross sectional descriptive survey of LAPMs related family planning service assessment involving observation of FP client- provider interaction, provider interview, client exit-interview and assessment of supplies and materials was conducted in Mekelle town from April 25 to May 20,2008 in six service delivery points: three health centers, two hospitals and one FGA clinic.

4.2 Study population and sampling procedure

The subject of the study were all family planning clients who visited the service delivery points and all health workers who were providing family planning service during data collection days from May 5-20,2008 at the three health centers [Mekelle HC, Kassech HC, Semen HC,], Mekelle family guidance, Mekelle hospital, and kuha hospital. The fact that the six service delivery points were

Seeing at least 20 clients per day based on their pattern of client flow was the criteria used for selecting the six SDPs for the study.

Data was collected continuously until the required sample size was obtained. All family planning users who come to the service delivery points were included and the number of providers selected for the study was determined by the number of health workers providing family planning services in the health institutions during data collection. And all working days of the week and the normal working hours of the days were considered.

4.3 Inclusion and Exclusion criteria

4.3.1. Inclusion criteria

- All health providers who happened to be providing family planning service on the day of the study were included in the study.
- All family planning clients who came to the service delivery points were included.

4.4 Sample size determination for exit interview

The required sample size was determined using the following assumptions to estimate sample size of single population proportion.

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

Assumptions:

Desired precision (d) = 5%

Expected prevalence (p) proportion of new family planning clients who received information on multiple FP methods (LAPMs) from the provider is 52 %.(Guinea)

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

Hence, the calculated sample size was 384. Adding a 10 % non-response rate gave the required minimum sample size (n) 422.

4.5. Data Collection Instruments

Questionnaires with different sections were prepared for client exit interview, provider interview, availability and functionality of facilities for provision of long acting and permanent family planning methods, service statistics were reviewed and guide for observation during provider-client interaction on counseling session were used.

4.6. Data Collection

- A questionnaire was used to collect information on supplies, and equipment important for providing quality family planning services especially for LAPMs. Information was gathered through interviewing.
- An exit interview was conducted for information regarding the client's experience at the facility, satisfaction with services, history in FP use, and LAPMs knowledge and understanding. Family planning clients were interviewed.
- Family planning service providers were interviewed for information on their qualifications, work experience, training, and supervision and their attitude regarding LAPMs**.**
- Service statistics was reviewed for information regarding LAPM services provided.

The questionnaires were first translated into Tigrigna and back translated into English to assure consistency. Then questionnaires were pre-tested at health institution which was not selected for the study. After, one day training was given to data collectors. Six trained health officers conducted the observation during client-provider interaction and data collected on the availability of necessary resources for provision of long acting and permanent family planning and related services. The observer was given a copy on steps of counseling process for providing family planning methods that was adapted a standard tool from FMOH *"A guide for counseling module 5"* which could make the observer evaluate whether the provider performed counseling according the guideline and Client exit interview were made by six trained nurses. Completeness and consistency of data was checked by the principal investigator at a daily basis.

4.7. Indicators or variables.

Independent variables

- Client/user characteristics: Socio- demographic characteristic such as Age, occupation, marital status, Educational level, Religion, fertility , knowledge, satisfaction with services, history in use LAPMs …
- Provider chacteristics: qualifications, work experience, training, and supervision and their attitude regarding LAPMs**.**
- Facility characteristics: Supplies, equipments, IEC materials, service hours, method availability, and infrastructure.

Dependent variables

- service provision (provision of information to clients on multiple FP methods)

4.8. Data processing and Analysis

Data that were collected on paper forms were entered and analyzed using SPSS. Cleaning, coding and analysis were employed by the investigator. Accuracy was improved through double entry. Descriptive statistics: (frequencies, Means, and percentages) and graphs were employed.

4.9. Operational definition

Performance need assessment: is identifying performance gaps or problems and gives you the information you need.

Long acting contraceptive method: IUDs, implants are categorized as long-acting contraceptive methods that they do not require daily use or repeated visits to obtain resupply. and IUCDs are effective for at least 12 years, although they are labeled for 10 years. Implants, depending on the type, last for up to three to seven years.

Permanent contraceptive methods: Female sterilization, or tubal-ligation, and vasectomy are permanent methods. Permanent methods are only appropriate for couples who have achieved their desired family size.

Informed choice: clients have clear, accurate, and specific information that they need to make their own reproductive health choices that means clients have a range of family planning methods to choose from, have a choice whether and how they want to be treated, and to make their own decisions**.**

Information given to clients: the information imparted on the different types of contraceptive methods by a provider during service contact to enable a client to choose a contraceptive methods effectively (Especially about LAPMs).

Waiting time: the time gap between the client's arrival at SDPs and the time the client received family planning services.

Understanding: knowing what the method is or how to use it.

4.10 Ethical consideration

Ethical clearance was obtained from Addis Ababa University, faculty of medicine ethical committee.Permition for conducting the study was secured from the Tigray regional health bureau. Then official letter was written to each service delivery points. Consent was also obtained from all the study participants after they were briefed about the objectives and the aim of the research. And Confidentialities of the information gathered were assured to the interviewee.

5. RESULTS

5.1. Exit interviews

5.1.1. Socio-demographic characteristics

A total of 422 clients were included in the exit interview. Out of these 346 were continuing clients, and 76 were new clients. The group with the highest proportion, 152 (36%) were in the age group 20-24 years, the mean age of clients was 26.2 (±5.8) years, 386 (91.5%) were married and the mean number of children alive was 2.46 (±1.4). Regarding religious affiliation 403(95.5%) of them were orthodox Christians. 104(24.6%) were illiterate and 240(56.8%) were house wife by occupation. (Table 1)

5.1.2. Fertility patterns

When asked if they would like to have more children 291(68.9%) clients responded in the affirmative, of those who wanted more children 269(92.4%) wanted their next birth after two to six years.

5.1.3. Family planning practice

Over three fourth; 327(77.5%) of the interviewed clients responded that they had ever used a family planning method and the rest of clients never used any modern contraceptives before the current method. Of those who had used a method 71(21.7%) and 256(78.3%) had used pill and injectables respectively. Family planning methods currently on use are the injectable 392(92.9%) followed by the pill 30(7.1%), but none of the long acting and permanent contraceptive

methods (IUCD, implants, female sterilization and male sterilization) were on use. Out of the total clients 312 (73.9%) and 99(23.5%) were using the method for spacing and limiting respectively.

Table 1: Socio- demographic characteristics of family planning clients interviewed in six service delivery points, Mekelle town, May 2008(n=422)

Characteristics	number (%)
Age	
15-19	34(8%)
20-24	152(36%)
25-29	126(29.8 %)
29-34	60(14.2%)
35-39	38(9%)
40-44	8(1.9%)
45-49	4(0.9%)
Marital status	
Married	386(91.5%)
Single	30(7.1%)
Divorced/widowed	6(1.4%)
Religion	
Orthodox Christians	403(95.5%)
Muslims	19(4.5%)
Educational status	
Illiterate	103(24.4%)
Read and write	13(3%)
1-8 grades	182(43.1%)
9-12 grades	87(20.6%)
Above 12 grade	37(8.8%)
Occupational status	
House wife	240(56.8%)
Government employee	25(5.9%)
Daily laborer	40(9.5%)
Merchant	52(12.3%)
Student	41(9.7%)
Others	24(5.7%)
Number of alive children	
0	36(8.5%)
1-3	305(72.3%)
>4	81(19.2%)

Out of the 76 new clients 41(53.9%) reported having received information on multiple family planning during this visit. Among those, the majority mentioned injectable 40(97.5%) followed by pill 38(92.6%), implants 20(48.7%), IUCD 19(46.3)), female sterilization 8(19.5%) and male sterilization 5(12.2%).while the rest clients were received information on the method that they asked about.

All interviewed Clients were also asked about their understanding of different family planning methods as either knowing what the method is or how to use it. The majority, (99.8%) of the clients were much more familiar with (injectable) temporary methods than with long acting and permanent contraceptive methods. Only 219(51.9%) of the clients knew what the IUCD is, 220 (52.1%) knew implants, 98(23.2%) knew female sterilization, and 94(22.3%) knew male sterilization. (Table 2)

Table 2: **Clients understanding of family planning methods in six SDPs, Mekelle town, May 2008(n=422)**

Methods	frequency	%
Injectable	421	99.8
Pill	390	92.4
Implants	220	52.1
IUCD	219	51.9
Female sterilization	98	23.2
Male sterilization	94	22.3

1.4. Client satisfaction with services and interpersonal relations

The average waiting time to get service was 36.2(±3) minutes. 112 (89.6%) Clients were satisfied with length of waiting time and the rest 13(10.4%) were dissatisfied. Out of 209 clients who had questions 183(87.6%) stated that the health care provider let them ask the questions and among these 175(95.6%) said that the health care providers responded to their questions satisfactorily. The Majority 353 (83.6%) of clients responded that consultation time with the health care provider was about the right length of time where as 57(13.5%) claimed that the consultation time was too short. Over all, concerning the service they received 98 (23.2%) stated they were very satisfied and 322 (76.3%) responded as just satisfied. Majority 415 (98.3%) of clients were informed to come again.

5.2. Health care provider interview

5.2.1. Professional background

A total of 10 female health care providers were interviewed in six service delivery points. Seven of the health care providers were nurses, one was midwife, and two were health assistants. The interviewed health care providers had been working for an average of 6.1(±3) years on FP service provision.

5.2.2. Practice on Family planning options

Among the 10 health care providers who were asked about their usual practice, eight of them counseled about implants, four about IUCD, three on female sterilization and two about male sterilization methods. As to the methods actually

ever provided, implants were provided by the six, IUCD by one, and none of the health workers ever provided female and male sterilization.

5.2.3. Knowledge and skills

Of the 10 health care providers interviewed six claimed that they had received training in counseling and providing implants but did not received anything about other LAPMs with in the last five years. Of those who had received the training four of them stated that they had been able to practice what they learnt while the rest two claimed that they had not been able to provide the service because of lack of materials, supplies (kits). Health care Providers were also asked if they felt they had the knowledge and skills necessary to practice long acting and permanent family planning services, four of the health care providers stated that they did not feel that they had knowledge and skills necessary to do long acting and permanent family planning services. Most of the health care providers recommended refreshment trainings on IUCD and implants insertion and removal, and on sterilization contraceptive methods.

5.2.4. Providers' Attitudes towards family planning

Most providers had generally favorable attitude towards permanent family planning methods. (Table 3)

Table 3: Information collected regarding health care providers' attitudes toward long acting and permanent contraceptive methods in six SDPs, Mekelle town, May 2008 (n=10)

IUCD

- Majority of the providers said that the IUCD is good and long term, but shouldn't be given to women who have multiple partners & women with PID.
- A few providers mentioned that it can cause bleeding, and is not given for the nulliparous, needs check up, and its' administration requires an operation room.

IMPLANTS

- The majority of providers mentioned that it is good, long acting, easy procedure, can be removed at any time, and has no age limitation.
- But fewer providers claimed that it can cause allergy, spotting and absence of menses.
- A fewer providers also mentioned that it can cause weight gain, weigh loss, and not given to Mothers with uterine or, breast cancer.

FEMALE STERILIZATION

- Most providers said that it is very effective, irreversible, that is good for old women.
- A fewer provider mentioned that it needs husband and wife commitment and it is also good for women who had had more than two caesarean section.
- But ends with divorce.

MALE STERILIZATION

- Most providers mentioned that it needs good counseling because it will not be easy for men to accept. And people have low awareness. It is permanent, irreversible, needs commitment.
- One provider said that it is more difficult procedure than tubal legation.
- A fewer providers did not know the method because the procedure is done in operation room.

5.2.5. Organizational support and supply

Eight of the ten health care providers who were interviewed confirmed that they had received a supervisory visit twice annually but none in both hospitals. During the visit the supervisors checked supplies, on job observation and cleanliness. They said that they often conduct performance reviews to evaluate both their clinical and administrative skills orally and in written form, but feedback from supervisors was sent irregularly.

Four of the assessed six service delivery points had no equipment, instruments, and supplies necessary to provide long acting and permanent family planning services. Most materials mentioned by the health care providers were implants kit, IUCD kits, blood pressure Apparatus, and contraceptives. Four of the health care providers felt dissatisfied with the organization of long acting and permanent family planning services at their facility.

5.3. Client - provider interaction

Observation on Client-provider interaction was made for 481 clients while providing family planning service in six delivery points. One hundred and five (21.8%) were new, 376(89.1%) were continuing family planning clients. Of the entire clients observed 113 (23.5%) of them were greeted by the health care provider during the beginning of the service. Surprisingly, all new clients were not asked about their reproductive intentions before they started to use any of the family planning methods. But the possible side effects of the method were discussed and monitored only for 85 (17.7%) clients. Majority 469(97.5%) clients were encouraged to come again with the proper specification of time and Few

minority; 12 (2.5%) clients were not informed about the next visit. and all clients were not informed about HIV/AIDS and STI prevention and control during counseling sessions. (Table 4)

Table 4: Information given to clients about the family planning methods during counseling sessions in six service delivery points, Mekelle town, May2008 (n=481)

	Informed	Not informed
Greet the client	113(23.5%)	368(76.5%)
Possible side effects discussed and monitored	85(17.7%)	396(82.3%)
Appointment for follow up	469(97.5%)	12(2.5%)

Upon observation among 105 new clients, less than half, 49 (46.6%) were explained about various FP methods in the six service delivery points. while the rest were explained the method that they asked about. Providers tend to discuss temporary family planning methods more often with their clients than they do long acting and permanent contraceptives methods. Among the observed clients; 10(20.4%), 3 (6.1%), 2 (4%) and 1 (2%) were informed about implants, intra uterine contraceptive device, female and male sterilization respectively. (Table 5)

Table 5: information given to clients about various family planning methods available in the six service delivery points, Mekelle town, May2008 (n=49)

Methods	Informed	%
Pill	34	69.4
Injectables	43	87.8
Implants	10	20.4
IUCD	3	6.1
Female sterilization	2	4
Male sterilization	1	2

In all the service delivery points family planning units were separated except that of Mekelle hospital was being used for antenatal and other gynecological services. Besides, insertions of implants was done out of the family planning unit with in the compound. All service delivery points had adequate water and electricity sources but lack supplies especially implant kits.

5.4 .Service availability

Except Mekelle family guidance clinic that offers family planning services for six days in a week, all the rest governmental health service institutions offer services during the five working days of the week. Except Mekelle hospital all facilities had posted signs advertising family planning services and four of the facilities had some form of information, education and communication materials about family planning mostly in form of posters. Most of the IEC materials show both long term and permanent contraceptive methods.

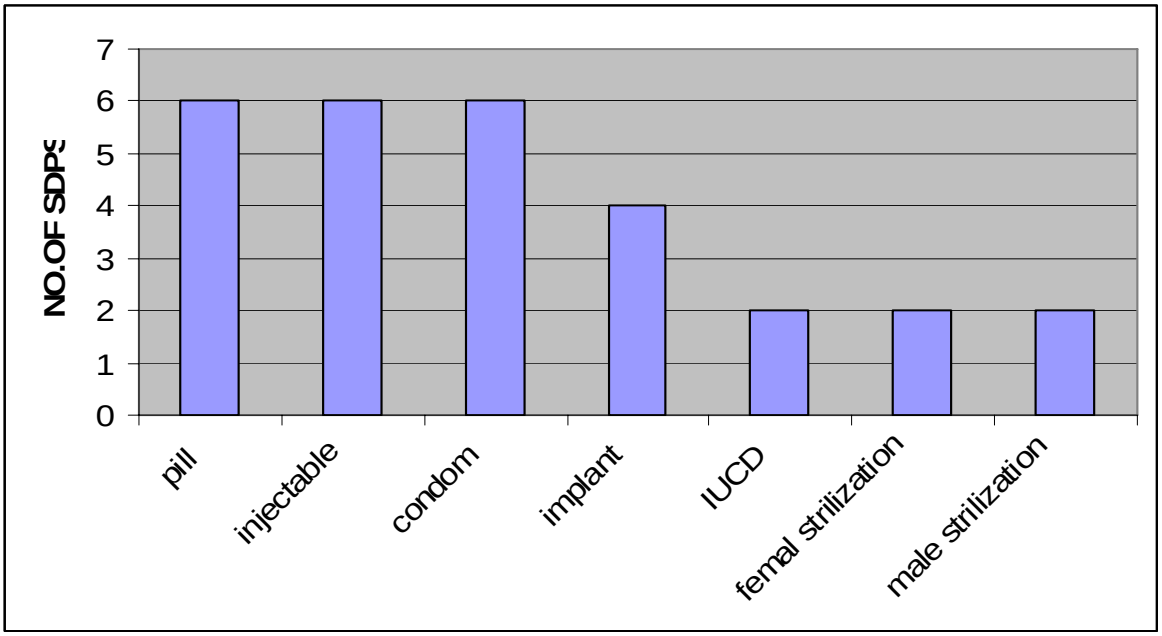
All service delivery points except Mekelle family guidance Clinic reported that they often encounter stock-outs of supplies for providing family planning services. Four and Five of the six SDPs reported running out of pills and implants respectively in the last six months that continued till the day of data collection. (Table 6)

Table 6**: Stock-outs of contraceptives in the six service delivery points, Mekelle town, May 2008(n=6)**

Types of contraceptives	Facilities with stock-outs of contraceptives
Pill	(4) 66.7%
Inject able	(1)16.7%
Implants	(5) 83.3%

All service delivery points were asked about any existing problems regarding to provision of LAPMs. Having lack of manpower, unavailability of some methods especially implant kits, absence of health professionals with special training were among the commonest problems mentioned by the health care provider in all the SDPs, but the Mekelle family guidance clinic had range of FP method choices. A good range of family planning services were offered only in Mekelle hospital and Mekelle family guidance clinic. (Fig 1)

Figure 1: Types of family planning methods provided in the six service delivery points, Mekelle town, May2008



5. Service statistics

When all health facility service statistics from July 1 to December 30 2007 were considered the data shows that temporary family planning methods contributed the highest percentages. While low usage of long acting and permanent family planning methods: 0.5% of clients used IUCD, 0.53% used implants, 0.02% used female sterilization, and male sterilization no cases with in the six months at all the service delivery facilities assessed. (Table 7) Out of the 96 IUCD users recorded in just two health facilities, Mekelle family guidance had the higher users of IUCD (84) 87.5 % while the rest (12) 12.5 % users were from Mekelle hospital. Out of the 109 users of implants: (82) 75.2% had from Kasech health center, (10) 9.2% had from Mekelle hospital, (6) 5.5% had from Mekelle health center, (11) 10.1% had from Mekelle family guidance clinic. All the four female sterilization users were from Mekelle hospital.

Table 7: Total clients by family planning methods at the six service delivery points Combined from July 1 to December 30 2007, Mekelle town, May 2008

Pill	Injectable	IUCD	Implants	Female Sterilization	Male sterilization	total
4123	16391	96	109	4	0	20723
19.9%	79.1%	0.5%	0.53%	0.02%	0	100%

6. DISCUSSION

In this survey, the utilization of contraceptive methods was totally dominated by short term family planning methods such as pill and injectable.Despite the fact that SDPs are widely available in Mekelle town and multiple methods of contraceptives are provided free of charge in most health institutions, utilization of long acting and permanent family planning methods remains low.

In this study the women who wanted more children desired to space their next birth after two years and above were 92.4% which is some what higher than the Study conducted in guinea which shows 67% of clients wanted their next birth with in two or four years (17). In this study nearly three-fourth, 73.9% of clients were using FP methods for spacing and nearly one- fourth, 23.5% are using for limiting. Similar study conducted in south Wollo shows 27.5% and 45.9% clients were using FP methods for spacing and limiting respectively (27). So the clients from this survey may have desired long term spacing or permanent contraception represent potential users for implant, IUCD, Tubal Ligation or vasectomy. But almost all women are eligible for IUDs, implants, and/or sterilization and all men who do not want more children are eligible for vasectomy. Of course, permanent methods are only appropriate for couples who have achieved their desired family size (11)

The most commonly used family planning methods in this study was found to be the injectables 92.9% followed by pill 7.1%. The study in north Gonder shows injectable 74.4% and pill 20 % and a study in Jimma zone also show 55.9% use

injectable and 43.3% use pill (29, 30). In all these studies and others like EDHS in Ethiopia temporary family planning methods were most dominant compared to Long-acting and permanent methods which are by far most effective (99 percent or greater) methods of contraception available and are very safe and convenient (1).

In this study the clients were much more familiar with temporary methods than long acting and permanent contraceptive family planning methods. Only 51.9%, 52.1%, 23.2%, and 22.3%, of clients knew what IUCD, implants, female and male sterilization respectively. Similar study in guinea shows that only 35% of the women knew about IUCD while 9% knew male sterilization and 50% knew about female sterilization which is higher than this study with the knowledge of female sterilization (17). These clearly indicate substantial proportions of clients did not know about long acting and permanent contraceptive family planning methods. This could be because the injectable and pills were the most commonly discussed methods and no much discussion was made concerning long acting and permanent methods of contraception.

Regarding the information provided on the specific FP method about 52% of new clients in Guinea reported having received information on multiple methods but less proportion on long acting and permanent family planning methods: IUCD 36.7%, female sterilization 27.5%, male sterilization 9.2% (17). In Ghana an average of one in five observed and interviewed clients reported that during the current visit they did not receive information on the specific method (16). And a study conducted in Uganda shows less than one half of the new clients were

advised on long-acting or permanent family planning methods (26). A study conducted in Jimma zone also shows 31% of clients were explained about various methods: 19.7% about IUCD, 11.3% about implant, 2.8% about surgical methods (30). where as in this study 53.9% of interviewed and 46.6% of observed new clients were provided information on multiple contraceptive methods: 6.1%, 20.4%, 4%, 2% about IUCD, implants, female and male sterilization methods respectively, which is some what higher than the study conducted in Ghana and Jimma zone but lower compared to the finding in Guinea and similar with the finding in Uganda. The discrepancy between the proportion of exit interviewed and observed clients receiving the information might be due to clients who could report as having the information even if they obtained it from other sources such discrepancy was also noted in studies conducted in Zimbabwe and Ecuador (20).

In this study all of the ten health care providers discussed with their clients about pill and injectables and eight about implants, four about IUCD, three about female and two about male sterilization methods. In terms of methods actually ever provided, pills and injectables were provided by all health care providers, while implants and IUCD were provided by six and one health care provider respectively, none of the health care providers had ever provided female and male sterilization methods. Substantial evidence from Taiwan, south-Korea, Thailand and Hong Kong indicates that a restricted choice of contraceptive methods, not provided with enough information has constrained the opportunity

of individual couples to obtain a method that suits their needs, resulting in lower levels of contraceptive prevalence (14).

In this study health care Providers have good attitudes regarding LAPMs However; most of the SDPs did not have IEC materials such as flipcharts to provide information about LAPMs. There was more concern on temporary family planning method than offering information about LAPMs which is similar with the studies done in Ghana and Guinea where providers have good attitudes regarding LAPMs but are not given clear expectations regarding their performance in providing information about LAPMs. Also, information education and communication (IEC) materials such as flipcharts, which are used to discuss family planning with clients, tend to provide more information on temporary methods (16, 17). However, ineffective IEC and counseling may result in frustration, discontinuation and method failure with all its'consquences (29).

In this study all observed new clients were not asked about their reproductive intentions where as studies conducted in Ecuador and Jimma zone showed that 37% and 65.7% clients were not asked their reproductive intentions before initiation of contraceptive methods respectively(20,30). How ever it was very helpful for the appropriate choice of method and it could have helped to avoid the dissatisfaction of some clients for whom their choice was not provided.

Regarding waiting time, the study conducted in Bangladesh showed that the average waiting time for family planning was 30 minutes and the proportion of clients who expressed dissatisfaction was 28.2% (33) and the average waiting time conducted in Jimma zone was 31.7 minutes and the proportion of

dissatisfied clients was 10 9%(30) where as the average waiting time in this study was 36.2 minutes and the proportion of dissatisfied clients was 10.4% which is some what longer waiting time than the studies and similar with the proportion of dissatisfied clients conducted in Jimma zone. Three hundred fifty three (83.6%) of clients responded that consultation time with the health care provider was acceptable length of time where as the rest 57(13.5%) claimed that the consultation time was too short. Though level of satisfaction with consultation time is relative, it is one potential area that affects clients' satisfaction with the service provided.

The proportion of clients who expressed dissatisfaction with service of facility in this study was minimal 3(0.7%), and proportion of clients who expressed dissatisfaction with solutions given by the provider was 9 (4.3%) which is lower than study conducted in guinea where 6% and 3% clients dissatisfied with service they received and the solution given by the provider (17). Even though the proportion is very small, this could reflect low technical competence or Low counseling skills in problem solving.

In this study almost all clients reported that they were informed to come again where as the observational finding showed that 2.5% of clients were not informed. This reflects the discrepancy of results between exit interview and observation.

In this study all clients (100%) were not informed about HIV/AIDS and STI prevention and control during counseling session, this is similar with a study conducted in north Gonder where 99% of clients were not informed (29). Thus in Ethiopia, which is one of hardest hit countries by HIV/AIDS in the world and the third in the number of HIV, infected people in sub-Saharan country. This is missed opportunity for HIV/AIDS prevention and control (32).

The study conducted in Tanzania shows that training and improving problem skill of providers improved quality of care in family planning services (34) how ever, in this study three-fifth of health care providers were trained on implants provision which is higher than a study conducted in Ghana where only one fifth of health care providers had attained training on LAPMs (IUCD) (16).

In Uganda Long-acting and permanent family planning services were available at a total of 31 sites which included government, private and non-governmental organization (NGO) facilities. Of these, seven sites were fully trained and equipped to provide long acting and permanent family planning methods (26) but in this study except in Mekelle hospital and family guidance clinic, the long acting and permanent family planning services were not fully available. The availability of services continues to affect both the use and the accessibility of long acting and permanent family planning services (31). This is the biggest barrier against the adoption of long acting and permanent family planning methods, associated to service poor information and quality of service issues. So the usage of wide range of contraceptive method mix improves the quality of family planning

services rendered to the community and ensures sustainability of the services [27].

In addition to that the inadequacy of supplies should be a cause for concern, in this study five of the six service delivery points reported stock -outs in the last six months of supplies need for providing LAPM family planning services which is higher than In Ghana where the stock-out was 11% (16). And Out of the six SDPs four, and five facilities reported running out of pills and implants respectively in the last six months continued till the data collection. Those makes the rang of method mix minimized in the service delivery points. Drops in implant use may be associated with stock-outs. The fall in the levels of use may also have been caused by significant changes at service delivery points such as skilled staff turn-over, or quality-related shortcomings as has been found by numerous studies in East and Southern Africa including Kenya, Botswana, Zimbabwe and Malawi (34).Generally, this study revealed several constraints in the provision of LAPMs services, which can be implied as areas of possible improvement including: method unavailability, supply inadequacy, lack of training, inadequate information provision about specific methods in most SDPs.

7. STRENGTH AND WEAKNESS OF THE STUDY

Strength

1. Qualified data collectors (health professionals) were used for observation during client-provider interaction and exit client interview.
2. Different types of data collection instruments were used to collect data from different sources to increase validity of the study.
3. A standard tool"FMOH Guide for counseling module 5" was adopted during observation on FP counseling sessions.

Limitations

1. The study was institutional based that might undermine the results.
2. Courtesy bias, respondants' answers are likely subject to social desirability.
3. Because of the non probability sampling method used, findings are not representative or generalizable

8. CONCLUSIONS AND RECOMMENDATIONS

- Unmet need for family planning, in terms of both spacing and limiting births shows in this study that many clients want to wait a number of years before having more children, or do not want any more children. Despite this, only less than half of the FP clients have received information on family planning from the provider. And when they received information from providers, it is mainly on temporary methods with fewer mentions of long acting and permanent contraceptive family planning methods even though many of the women were potential users of LAPMs.
- Clients were not learning more about LAPMs during consultations at the health facility, the reason is related to providers' approach to information-sharing and counseling. Providers tended to focus the family planning information they gave to a client on the method that she asked about, without first carrying on a discussion about her reproductive intentions, about her needs and to discuss how to address them. Providers have good attitudes regarding LAPMs however; they were more concerned on temporary family planning method and less about LAPMs.
- IEC materials Such as flipcharts, which are used to discuss family planning with clients, were not enough in the facilities which tended to provide more information on long acting and permanent family planning methods.
- Some providers reported that they had received training in counseling and family planning, yet very few had had an opportunity to utilize these skills, due

to stock-outs of necessary supplies and materials. However, many of providers expressed interest in learning more about LAPMs.

- Over the past six months, most facilities had run out of either contraceptives or other tools necessary for the provision of long acting and permanent family planning services. And only two of the health facilities could offer these services fully.
- Although providers reported receiving fairly supervisory visits, supervisors did not motivate and sent feedback to providers as needed.

There fore based on this finding the recommendations are:

- The services should be made more widely available and supply stocks should be maintained and replaced speedily.
- Service providers should be trained in order to improve:
    - The quality of provider interaction (information provision and counseling) with clients, especially new ones.
    - Providers' knowledge and understanding of the methods and procedures.
    - Staff competence in performing the procedures.
- Printed materials should be made available to interested clients.
- Promotion of the use of long acting and permanent method to increase clients' information regarding LAPMs. Couples should also be targeted through promotion and publicity campaigns and advertisements to further

encourage their participation in couple discussions and decisions on the use of the methods.

- Facilities that provide these services must be adequately equipped and stocked to provide the services. Those facilities that do not provide these services must know where and when the services are available at other sites so that they can refer clients to alternate sites and help the clients receive the services they need.

- Regular supervisory visits and feedback should be designed to improve service quality.

9. REFERENCES

1. USAID, Long-Acting and Permanent Methods of Contraception: Meeting Clients' Needs[WWW.poptechproject.com/pathfainder]
2. Ethiopia demographic and health servey,2005
3. population reference bureau,.2005
4. 2003, World Population Data Sheet, Population Reference Bureau
5. ORC Macro Calverton, Evaluation of Program Options to Meet Unmet Need for Family Planning in Ethiopia, Addis Ababa, Maryland USA November, 2002
6. WWW.safemotherhood.org/init_facts.htm, accessed June 2005.
7. John B, Elof J, Future trends in Contraception in the developing world: Prevalence and method mix Policy Research Division, Population Council, 2000 No. 141
8. George F.Brown Tunisia's experience in family planning, 1968, p59-68
9. Farzaneh R-F, Iran's family planning program: Responding to a nation's Needs, Population Reference Bureau, June 2002.
10. Health and Health Related Indicators, Federal Democratic Republic of Ethiopia, Ministry of Health, Addis Ababa, Ethiopia, 2003/4
11. WHO's latest Medical Eligibility Criteria for Contraceptive Use,2004
12. Jacobstein R, Long-acting and permanent contraception: an international development, service delivery perspective[WWW.cpc.unc.edu/publication]

13. .United Nations Population Fund (UNFPA), Programme of Action Adopted at the International Conference on Population and Development*, Cairo,* New York: UNFPA, 1996, p. 53.

14. Freedman R and Berelson B, The record of family planning programs, *Studies in Family Planning,* 1976, 7(1):1–40.

15. By John Ross, Karen Hardee, Elizabeth Mumford and Sherrine Eid Contraceptive Method Choice in Developing Countries, *2001, 28(1):32–40*

16. An assessment of Trend in the use of the IUCD in Ghana, May 2003.

17. Improving the Use of Long-Term and Permanent Methods of Contraception in Guinea: A Performance Needs Assessment E&R Study #1 May 2005

18. Mehboob Sultan, MSc, John G. Cleland, MA, and Mohamed M. Ali, Health Assessment of a New Approach to Family Planning Services in Rural Pakistan July 2002, Vol 92, No. 7

19. Edwin Montufar, Carlos Morales APROVIME, Improving Access to Long-Term Contraceptives in Rural Guatemala through the Ministry of Health, August 2005

20. RUTH E, JANE T. Monitoring Quality of care in family planning programs: A comparisons of observation and client exit interviews. International family planning perspective2001;27(2):63-70.9

21. Ndhlovu L*., Quality of Care and Utilization of MCH and FP Services at Kenyan Health Facilities*, The Population Council, 1999

22. Bashir Ahmed, Determinants of Contraceptive Use in Rural Bangladesh: The Demand for Children, Supply of Children, and Costs of Fertility Regulation, Vol. 24, No. 3. (Aug., 1987), pp. 361-373.

23. David K. Guilkey; Susan Jayne, Fertility Transition in Zimbabwe: Determinants of Contraceptive Use and Method Choice Vol. 51, No. 2. (Jul., 1997), pp. 173-189.

24. MARY ARENDS-KUENNING, FLORA L. KESSY, The impact of demand factors, quality of care and access to facilities on contraceptive use in Tanzania

25. Revitalizing the IUD in *Kenya*, Applying Lessons Learned to Strengthen FP/RH Services ,2006-no-2

26. SUSAN KASEDDE, LONG-term and Permanent Family Planning Methods in Uganda a Literature Review, OCTOBER 2000.

27. Mengistu Asnake, Lakachew Walie, Yilma Melkamu, Improving the range of contraceptive choices in rural Ethiopia Dev. 2006;20(2):74-78

28. World Health Organization, Assessment of reproductive health needs in Ethiopia, Geneva, 1999

29. Misganaw Fantahun,Quality of family planning services in north west ethiopia,oct-dec2002,19(3):196-199

30. Eskinder Loha,Mekonen Assefa,Chali Jira,Fasil Tessema, Assessment of quality of care in family planning services in Jimma zone, southwest Ethiopia,jan.2003,18(1):6-16

31. Arkutu, A. *Family Planning in Sub-Saharan Africa: Present Status and Future Strategies*., International Journal of Gynaecology and Obstetrics, 50 Suppl. 2 (1995) S28-S34

32. MINITRY OF HEALTH (ETHIOPIA).AIDS in Ethiopia. fourth edition,Octeber2002.Adis Ababa

33. ALDANA M,PIECHULEK H,AL-SABIR A. Client satisfaction and quality of health care in rural Bangladish.Bulletin of World health organization2001;79:512-517

34. Bradly J, Wambwa G, Beattie K, Dwyer J.Quality of care in family planning service: an assessment of change in Tanzania 1995 to 1996.New York, AVSC international, 1998; 26p.

Annex-1 :Questionnaire (English Version)

QUESTIONNAIRE ON ASSESSMENT OF STATUS OF LONG TERM AND PERMANENT CONTRACEPTIVE METHODS IN MEKELLE

01. Name of the area _____

02. Questionnaire identification no. _____

03. Address of the client: _____

INTRODUCTION: How are you? My name is _____. I would like to inform you that you and I would have a short discussion concerning this study. Before we go to our discussion, I will request you to listen carefully to what I am going to read to you about the purpose and general condition of the study and tell me whether you agree or disagree to participate in this study.

Consent form

The purpose of this study is to improve the use of long term and permanent contraceptive methods in Ethiopia. The study will be conducted through interviews. I am asking you for a little of your time, about 25 - 30 minutes, to help us in this study. In the end, it is hoped that the information you give us could help to improve this method of family planning. The interview involves intimate and private life questions. I would like to assure you that this privacy should strictly be maintained throughout. A code number will identify every participant and no name will be used. Your responses to any of the questions will not be given to anyone else and no reports of the study will ever identify you. If a report of results is published, only information about the total group will appear.

The interview is voluntary. Your participation / non-participation, or refusal to respond to the questions will have no effect now or in the future on services that you or any member of your family may receive from the service providers.

Are you willing to participate in this study?

1. [ ] Yes. 2. [ ] No

Thank you!!

If the study subject agrees to participate in the study, start the interview.

03. Interviewer signature certifying that informed consent has been given verbally by the respondent.

Name _____ Signature _____Date _____.

NB:

1. No need of enforcing the clients to be included in the study.

2. Please register the age and sex of study subjects who refuse to participate in the study

Client information

Client Background

Now I would like to begin by asking you a few questions about yourself and your family:

Serial no	Question	answers	cods	remark
101	What is your marital status?	Married Divorced/separated/widowed Single	1 2 3	
102	How old are you?	15-19 20-24 25-29 30-34 35-39 40-44 45-49 50+	1 2 3 4 5 6 7 8	
103	What is your religion?	Orthodox Muslim Others	1 2 3	
104	How many living children do you have?			
105	Do you want to have any children/any more children?	Yes No Don't know	1 2 88	No ➛ Go to Q108
106	. *If Yes,* how many?			
107	When?			
108	What is the highest level of school you have completed?	Illiterate Read and write Primary[1-8] Secondary[9-12] 12+	1 2 3 4 5	
109	What is your occupation?	House wife Government employee daily labourer Merchant Student Other specify	1 2 3 4 5 6	

Family planning information

201	Have you ever used a contraceptive method?	Yes No Don't know	1 2 88	No ➔ Go to 203
202	If yes which method?[do not read CIRCLE all methods mentioned]	PILL injectable IUD Condom implants Female sterilization Vasectomy Other *(specify)*:	1 2 3 4 5 6 7 8	
203	I will now mention different family planning methods and would like you to tell me what you understand about each method. If you do not know what it is, say "I don't know." Pill 1 ---------- Injectable 2 ---------- IUCD 3 ---------- Condom 4 ---------- Implant 5 ---------- Female sterilization 6 ---------- Male sterilization 7 ----------			
204	Did you receive any information or did anyone talk to you about family planning methods during your visit?	Yes No Don't know	1 2 88	
205	Did you receive any information about these methods during this or previous visits? *(Read the list.)*			
	METHOD			
	Pill	1		
	Injectables	2		
	IUD	3		
	Condom	4		
	Implants	5		
	Female sterilization	6		
	Vasectomy	7		
	Others	8		
206	Would you ever consider getting sterilization?	Yes No Didn't want to respond	1 2 99	
207	Would your partner ever consider getting sterilization?	Yes No Not applicable Didn't want to respond	1 2 77 99	
208	Which methods are you now using?	PILL INJECTABLE IUD	1 2 3	

		Condom implants Female sterilization Vasectomy Other *(specify)*:	4 5 6 7 8	
209	Reason for current use?	Side effect of the previous method Spacing Limiting Better method use others	1 2 3 4 5	
210	The method which you use currently, is that your choice	Yes no	1 2	

Client Satisfaction with service

301	Do you feel that today you received the information and services you wanted?	yes No Some but not enough Don't know	1 2 3 88	
302	Do you feel that your consultation with the clinic staff was too short, about the right length of time, or too long?	Too short About right Too long Don't know	1 2 3 88	
303	Do you think that the staffs at this clinic are skillful?	Yes No Don't know Didn't want to respond	1 2 88 99	
304	During this visit did you have any questions you wanted to ask?	Yes No	1 2	
305	*If Yes*, did the provider let you ask the questions?	Yes No	1 2	➔ if no Go to Q. 307
306	*If Yes*, did the provider respond to your questions to your satisfaction?	Yes No Partially	1 2 3	
307	During the consultation, did you feel that the clinic staff was friendly?	Yes No	1 2	
308	For your visit today, did you have an appointment at a specific time?	Yes No	1 2	

309	About how long did you wait between the time you first arrived at this clinic and the time you were seen?	No wait ---------hours(minuts)	1 2	➔ if no wait Go to Q311
310	Do you feel that your waiting time was reasonable, or too long?	Reasonable Too long Don't know	1 2 88	
311	If a friend of yours wanted family planning services, where would you recommend her to go?	Come to this facility somewhere else Don't know	1 2 88	➔ Go to .313
312	Why would you encourage her to go to somewhere else? *(Circle the most important reason.)*	More convenient, closer Better quality service Wider range of services Services cheaper Likes/trusts provider in the other place Other *(specify)*	1 2 3 4 5 6	
313	Apart from this clinic, do you know of any other place near your home where you can get family planning services?	Yes No	1 2	
314	Overall, how satisfied are you with the visit to the clinic?	Very satisfied Satisfied Unsatisfied	1 2 3	
315	Do you have any suggestions for improving the services provided by this facility?			

Provider information

Professional background

S.n	Questions	answers	cods	remarks
401	What is your qualification?	Doctor Midwife Nurse Assistant Nurse others	1 2 3 4 5	
402	How long have you worked in the health services?[providing FP care]			
403	Do you have any norms and procedures, flow chartes, guide?	Yes No	1 2	
404	In the last six month have you received verbal or written recognition for doing your work well?	Yes no	1 2	To406
405	If yes from whom	Regional health office District health office On site office other	1 2 3 4	
406	Which of the following	Materials(watch, gold) Money Training Recognition others	1 2 3 4 5	
	Organizational support and supply			
501	Do the facility received any supervision(woreda health office)	Yes no	1 2	To506
502	How many times per year			
503	Have you ever received feed back on time	Yes No Don't know	1 2 88	To506 =
504	Were you able to use this information in a way that helped you to do your job better?	Yes No Don't know	1 2 88	
505	If no explain why			
506	In the last six month do you receive supervision from regional health office	Yes No Don't know	1 2 88	
507	When the supervisor comes, what does he or she do	Check supplies Perform administrative duties Observe provider duties others	1 2 3 4	
508	Who do you go to when you have questions about an administrative task?	Woreda health office On-site office	1 2 3	

		Regional health office Other *(specify)*:	4	
509	Who do you go to when you need medical supplies or medicines?	Woreda health office On-site office Regional health office Other *(specify)*:	1 2 3 4	
510	Do clients have to bring their own supplies for the services they will receive (i.e., buy gloves)?	Yes No Don't know	1 2 88	
511	Do you receive regular reviews of your job performance from your supervisor at least once a year?	Yes No Don't know	1 2 88	To part 3
512	How are the reviews conducted	Verbally In writing Verbally and in writing	1 2 3	
513	What is the purpose of the performance review?	To assess clinical skills To assess administrative skills To assess *both* clinical and administrative skills Don't know	1 2 3 4	
Organizational supply				
601	In general, do you feel the physical environment is adequate for you to do your job well?	Yes No Don't know	1 2 88	
602	Do you have the equipment, instruments, and supplies necessary to do your job well? specially for LTPMs	Yes No Don't know	1 2 88	To604
603	If *No*, what equipment, instruments, and supplies do you need?	_____		
604	Are you satisfied with the way the services provided in this facility are organized?	Yes No Don't know	1 2 88	
605	*If No*, what changes would you introduce in your work environment and this facility?	_____ _____		
Knowledge and skills				
701	Have you received training in family planning and reproductive health in the past five years?	Yes No Don't know	1 2 88	If No or DK,skip to 705
702	In what areas/procedures in family			

	planning did you receive training? What did you learn in these courses? *, probe as: family planning, counseling, IUD insertion and implantation* Any other areas?	_____ _____		
703	Have you been able to apply in your job what you learned in the training course?	Yes No Don't know	1 2 88	
704	*If No*, why not?	_____		
705	Do you feel you have the knowledge or skills necessary to do your present job?	Yes No Don't know	1 2 88	If Yes, skip to Q. 707
706	What knowledge and skills do you feel you still need in family Planning?			
707	Have you yourself counselled or provided information to women, couples, or men on contraceptives in the last three months?	Yes No Don't know	1 2 88	No ➔ Go to Q.709
708	Which methods have you yourself discussed with women, couples, or men in the last three months? *Interviewer: Do not read list. Multiple responses are allowed. Choose response from list, if possible;*	Pill Injectable IUCD Condom implant Female sterilization Male sterilization other *(specify*	1 2 3 4 5 6 7 8	
709	Which of the following family planning methods have you actually provided to clients yourself in the last three months?	Pill Injectable IUCD Condom implant Female sterilization malesterilization other *(specify*	1 2 3 4 5 6 7 8	
710	If a client would like a method or procedure that is not available at this facility, what would you say to her or him? *Interviewer: Do not read list. Multiple responses are allowed. Choose response from list, if possible;*	Refer him or her to another facility Ask him or her to return when new stocks arrive Recommend another method while waiting for desired method Other *(specify*	1 2 3 4	
711	Are there any other methods you know about which you are not providing? *Interviewer—Probe: Do you know about Norplant implants? Vasectomy? Female sterilization?*			

Interviewer—Say I am going to ask you what you think about specific family planning methods. Please tell me your opinion/what you believe regarding the method."

Q	Method	Opinion
712	1- IUD	
	2- Implants	
	3-Female Sterilization	
	4 -Vasectomy	
713	Do you provide information and counselling on STI or HIV/AIDS prevention and control	1-Yes 2-No

Service availability information

901	How many days per week is family planning services offered at this facility? _____ days/week			
902	Is there a sign announcing that family planning services are available?	Outside the facility Inside the facility Both inside and outside the facility No sign visible	1 2 3 4	
903	Indicate the number of staff who provides family planning at this facility within each designation.	Specialist (ob/gyn) General practitioner Nurse Midwife Assistant nurse Other medical staff	1---------- 2--------- 3--------- 4---------- 5--------- 6---------	
904	Which FP IEC materials are available?			
			YES	NO
	FP posters on walls Flipchart FP brochure/pamphlet for clients FP user instructions Samples of contraceptives Anatomical models Others	1 2 3 4 5 6 7	1 1 1 1 1 1 1	2 2 2 2 2 2 2
905	Health education about long acting and permanent family planning method		yes	1
			No	2
906	In the last six months, which contraceptives have ever been out of stock? Type of contraceptive Check (✓) if out of stock in last six months	pills Implants Injectables Condoms IUD	1--------- 2--------- 3--------- 4--------- 5--------- -	

907	Record below whether the facility provides each of the following methods.		Yes	No
		pills 1	1	2
		implants 2	1	2
		Injectables 3	1	2
		Condoms 4	1	2
		IUD 5	1	2
		Female sterilization 6	1	2
		Vasectomy 7	1	2
908	Do you have a record system for keeping track of Fp commodities received and dispersed	Yes No	1 2	
909	Are family planning commodities stored according to their expired date	YES No	1 2	
910	Is there a daily family planning activity register or log book?	Yes No	1 2	
911	Are monthly statistical reports about family planning activities sent to a supervisor or higher unit?	Yes No	1 2	
912	*If Yes*, is feedback received on reports?	Yes No Irregularly Not applicable	1 2 3 77	
913	Compile the statistics for the following table, wherever possible using a period of six consecutive calendar Mark "0" where there are no clients or methods issued.		No	%
		pills 1	---------	
		implants 2	---------	
		Injectables 3	---------	
		Condoms 4	----------	
		IUD 5	----------	
		Female sterilization 6	----------	
		Vasectomy 7	----------	
		TOTAL	---------	

Observation Guide

Instructions to the observer: **Start your observation when the provider establishes contact with the client.**

		YES	NO
1	Greets the client, making sure that she is comfortable and has the needed privacy		
2	Asks questions, allows the client to talk, and encourages the client to ask questions		
3	Asks the client about her reproductive health and FP intentions and if he or she has any preferences		
4	Provides information about the client's selected method and, if the client does not have any preference or changes her opinion, offers information about other methods		
5	Explains advantages and disadvantages of the selected method, including its side effects		
6	Uses clear and simple language, making sure the client has understood		
7	Clarifies any doubts or misconceptions about the methods, as appropriate		
8	Provides the client with enough supplies of the selected method (if pills, condoms)		
9	appointment for the next		

ANNEX 2: Tigrigna questionnaires

ከመይ ውዒልኪ/ካ

ሽመይ ---------- ይበሃል ኣብ ዝግበር መፅናዕቲ ምምሕያሽ ፅርየት ነዊሕን ቆዋሚ ዝዓይነቱ መከላኸሊ ጥንሲ ኣብ ድህስስ ድልየት ብቅዓት ዝተደረኸ ተሳታፍይ'የ።

ነዚ ፅንዓት ኣብ ነዊሕን ቀዋሚ ዝዓይነቱ መከላኸሊ ጥንሲ ዝተደረኸ ዘለኪ ተመክሮን ኣብዚ ትካል ዘለኪ ርኢቶ ናትኺ ሓበሬታ ኣገዳሲ ስለዝእኾነ ንዝግበረልኪ መጠይቅ ክትታሓባበሪ ንላቦ።

እቲ መጠይቅ ከባቢ ፍርቂ ሰዓት ዝውድእ እንትኸውን እቲ ኣብ መንነና ዝግበር መጠይቅ ሚስጥርነቱ ዝተሓለወ እዩ ንስኺ ኣብዚ መጠይቅ ምስታፍኪ ኣብ ውልቀ ስራሕኺ ዘምፅኦ ሳዕቤን የለን ሽምኪ ድማ ኣብ ዝግበር መጠይቅ ኣገዳሲ ኣይኸውንን። ናትኪ ተሳታፊነት ኣብ ብድሌት ዝተደረኸ እንትኸውን እንድሕር ደኣ ነዚ መጠይቕ ፍቃደኛ ኾይነኺ ባህ ንዝበለኪ ሕቶታት ምምላስን ንዘየደለኽዮ ድማ ነዘይ ምምላስን ከመኡውን እቲ መጠይቕ ናይ ምቁራፅ መሰልኪ ዝተሓለወ እዩ።

ስለዙይ ነቲ መጠይቅ ክቕፅል ፍቃደኛ ዲኺ

- እንድሕር እወ ኾይኑ መለሲ

  ዘይበረሃላ ነገር እንተሎ ክትሓትት ዕድል መሃብ
- እንድሕር ኣይፋለን ኮይኑ መልሲ ኣመስጊንካ ናብ ካልእ ምስጋር

ሀ. ንተገልገልቲ መጣነ ሰድራ ዝተዳለወ መጠይቕ

1. ውልቀ ታሪኽ ተገልገልቲ

ሰቕ	ሕቶ	መልሲ	ኮድ	ሓ/ደ	
101	»ነታት ሓዳር	1. ባዓልቲ ሓዳር 2. ዝተፋተሐት 3. ሓዳር ዘይገበረት			
102	ዕድመኺ ክንደይ እዩ	_____ዓመት			
103	ሃይማኖትኪ	1. ክርስትያን 2. እስልምና 3. ካልእ			
104	ክንደይ ቐልዑ አለውኺ	_____ ቐልዑ			
105	ተወሳኺ ቆልዓ ክህልወኪ ትደልዩ ዶ	1. እወ 2. ኣይፋሉን 88. አይፈልጥን	ናብ 108		
106	እወ እነተኾተኑ ክንደይ ቆልዑ ክህልውኺ ትደለዩ	_____ ቐልዑ			
107	ማዓዝ ክትወልዲ ትደልዩ	ድሕሪ_____			
108	ኩነታት ትምህርቲ	1. አይተምሃርኩን 2. ምንባብን ምፅሓፍን 3. ካብ 1-8ይ 4. ካብ 9-12ተ 5. ካብ 12+			
109	ኩነታት ስራሕ	1. በዓልት ሓዳር 2. መንግስቲ ሰራሕተኛ 3. ጉልበት ሰራሕተኛ 4. ነጋዲ 5. ተምሃሪት 6. ካሊእ			

2. ብዛዕባ መጣነ ሰደራ

ሰቕ	ሕቶ	መልሲ	ኮድ	
201	ምጣነ ሰድራ ቕድሚ ሕዚ ተጠቒምኪ ዶ ትፈልጢ	1. እወ 2. ኣይፋሉን	ናብ 203	
202	እወ እነተኾይኑ እንታይ ዓይነት መከላኸሊ ጥንሲ	1. ብኣፍ ዝውሰድ መከላኸሊ ጥንሲ 2. ብመርፈእ ዝውሰድ መከላኸሊ ጥንሲ 3. አብ ማህፀን ዝኣቱ (ሉፕ) 4. ኮንዶም 5. አብ ኩርናዕ ዝቕበር ዓይነት መከላኸሊ ጥንሲ 6. ምምካን ደቂ አንስትዮ 7. ምምካን ደቂ ተባዕትዮ		

		8. ካልእ		
203	ካብዚ ንታሕቲ ዝተዘርዘሩ ዓይነት መካላኸሊ ጥንሲ ነየንኣም ትፈልጢ	1. ብአፍ ዝውሰድ መከላኸሊ ጥንሲ 2. ብመርፈእ ዝውሰድ መከላኸሊ ጥንሲ 3. አብ ማህፀን ዝኣቲ (ሉፕ) 4. ኮንዶም 5. አብ ኩርናዕ ዝቕበር ዓይነት መከላኸሊ ጥንሲ 6. ምምካን ደቂ አንስትዮ 7. ምምካን ደቂ ተባዕትዮ		
204	ሓበሬታ መካላኸሊ ጥንሲ ዓይነታት አብ እዋን ግልጋሎት ረኺብኪዶ ትፈልጢ	1. እወ 2. አይፋሉን	ናብ 206	
205	እወ እንተኾይኑ አየናይ ዓይነት መከላኸሊ ጥንሲ	1. ብአፍ ዝውሰድ መከላኸሊ ጥንሲ 2. ብመርፈእ ዝውሰድ መከላኸሊ ጥንሲ 3. አብ ማህፀን ዝኣቲ (ሉፕ) 4. ኮንዶም 5. አብ ኩርናዕ ዝቕበር ዓይነት መከላኸሊ ጥንሲ 6. ምምካን ደቂ አንስትዮ 7. ምምካን ደቂ ተባዕትዮ		
206	ምምካን ደቂ አነስተዮ ዝዓይነቱ መካላኸሊ ጥንሲንምጥቃም ሓሲብኪዶ ትፈልጢ	1.እወ 2.አይፋሉን 99. መለሲ አይህበሉን		
207	ባዓልገዛኺ ምምካን ደቂ ተባዕትዮ ዝዓይነቱ መካላኸሊ ጥንሲንምጥቃም ሓሲቡዶ ይፈልጥ	1. እወ 2. አይፋሉን 77. ግልጋሎት የለን 99. መለሲ አይህበሉን		
208	ሕዚ ትጥቀምሉ ዓይነት መካላኸሊ ጥነሲ እንታይ እዩ	1. ብአፍ ዝውሰድ መከላኸሊ ጥንሲ 2. ብመርፈእ ዝውሰድ መከላኸሊ ጥንሲ 3. አብ ማህፀን ዝኣቲ (ሉፕ) 4. ኮንዶም 5 .አብ ኩርናዕ ዝቕበር ዓይነት መከላኸሊ ጥንሰ 6. ምምካን ደቂ አንስትዮ 7. ምምካን ደቂ ተባዕትዮ 8. ካልእ		
209	ምኽንያት ሕዚ ትጥቀምሉ መካላኸሊ ጥነሲ ንምንታይ እዩ	1. ብምኽንያት ሓልኪ እቲ ቐዳማይ መከላኸሊ ጥንሲ 2.አራሓሒቕካ ንምውላድ 3.ድሕር ሕዚ ንዘይምውላድ 4. ዝሓሸ ዓይነት መከላከሊ ንምጥቃም 5. ካልእ		
210	ሕዚ ትጥቀምሉ ዓይነት መከላከሊ ምርጫኺ ድዩ	1. እወ 2. አይፋሉን		

3. ዕግበት ተገልገልቲ

ሰቐ	ሕቶ	መልሲ	ኮድ
301	በቲ ዝረኸብክዮ ልጋሎት ዕግብቲ ዲኺ	1. እወ 2. አይፋሉን 3. እኹል አይኮነን 88. አይፈልጥን	
302	ምስ ባዓል ሞያ ዝነበረኪ ፃኒሒት ከመይ ረኺብክዮ	1. ሓፂር ጊዜ 2. እኹል ጊዜ 3. ነዊሕ ጊዜ 88. አይፈልጥን	

303	ክእለትን ብቕዓትን ባዓል ሞያ ፅቡቕዶ ትብሊዮ	1. እወ 2. እይፋሉን 88. አይፈልጥን 99. መልሲ አይህበሉን	
304	አብ እዋን ግልጋሎት ሕቶታት ኔሮምኪዶ	1. እወ 2. አይፋሉን	ናብ 307
305	እወ እነተኾይኑ ባዓለ ሞያ ክትሓቲ ዕድል ዶ ሂቡኪ ነይሩ	እወ አይፋሉን	
306	እወ እነተኾይኑ ዘዕገብ መለሲ ዶ ረኺብኪ	1. እወ 2. አይፋሉን 3. ብመጠኑ	
307	አቀራርባ ባዓል ሞያ ፅቡቕ ዶ ነይሩ	1. እወ 2. አይፋሉን	
308	ቕፀሮ መዓልቲ ተዋሂቡኪ ዶ	1. እወ 2. አይፋሉን	
309	ግልጋሎት ንምርካብ ዝተፀበኽዮ ሳዓት ክንደይ ይኸውን	1. ምፅባይ የለን 2. _____ ሳዓት	ናብ 311
310	ግልጋሎት ንምርካብ ዝተፀበኽዮ ሳዓት ከመይ ትገልፅዮ	1. ምኽንያታዊ እዩ 2. ብጣዕሚ ነዊሕ 88. አይፈልጦን	
311	ማሓዛኺ መከላኸሊ ጥንሲ ንኽትጥቀም እንተሓተተትኪ ናበይ ትሕብርላ	1. ናብዚ ተካል 2. ናብ ካልኢ ተካል 88. አይፈልጥን	ናብ 313
312	ናብ ካልእትካል እትሕብርላ ንምንታይ እዩ	1. ቕረባ ስለዝኾነ 2. ፅቡቕ ግልጋሎት ንኽትረክብ 3. ብዙሕ ዓይነት ግልጋሎት ስለዘሎ 4. ርካሽ ክፍሊት ስለዘሎ 5. እሙናት ሰብ ሞያ ስለዘለዉ 6. ካልእ	
313	ካብዚ ትከል ወፃኢ ግልጋሎት ምጣነ ስድራ ዝርከበሉ ቦታ ትፈልጢ ዶ	1. እወ 2. አይፋሉን	
314	ሓፈሻዊ ዕግበት አብዚ ትካል ከመይ ትገልፅዮ	1. ብጣዕሚ ዘዕግብ 2. ዘዕግብ 3. ዘየዕግብ	
315	አብዚ ትካል ክመሓየሽ አለዎ እትብልዮ ነገር እንታይ አሎ	_____ _____	

<u>የቕንየለይ</u>

ኣብ ግልጋሎት መጣነ ስድራ ንዝሰርሑ ሰብ ሞያ ጥዕና ዝቐርብ መጠይቕ

1. ኩነታት ሰብ ሞያ ጥዕና

ተቐ	ሕቶ	መልሲ	ኮድ	
401	ሞያኻ/ኺ ኣንታይ እዩ	1. ዶክተር 2. መዋልዳን 3. ነርስ 4. ተሓጋጋዚ ነርሰ		
402	ኣብ ግልጋሎት ምጣነ ሰድራ ንኽንደይ ዓመት ሰሪሕኻ	«_____ግዜ		
403	ንስራሕቲ ግልጋሎት ምጣነ ሰደራ ዝሕግዝ ከም ፍሎውቖርት ፤ጋይድ ኣለኩም ዶ	1. እወ 2. ኣይፋሉን		
404	ኣብ ዝሓለፈ ሽዱሽተ ኣዋርሕ ኣፍልጦ ፅቡቕ ስራሕኻ/ኺ ናይ ቃል ወይ ናይ ፅሑፍ ረኺብካ/ኪ ዶ ትፈልጢ	1. እወ 2. ኣይፋሉን	ናብ 406	
405	እንተዳኣ እወ ኾይኑ መልሲ ካብ መን	1. ካብ ክልል ጥዕና ቢሮ 2. ካብ ወረዳ ጥዕና ቤት ፅ/ት 3. ካብ ዝሰርሐሉ ቤት ፅ/ት 4. ካብ ካልእ		
406	እቲ ዝወሃብ መበራታትዓ እንታይ እዩ	1. ኣቕሓ (ሳዓት፤ ወርቂ) 2. ገንዘብ 3. ናይ ስልጠና ዕድል 3. ኣፍልጦ ምሃብ 4. ካልእ		

2.ኩነታት ሓገዛዊ ዑደት

ተቐ	ሕቶ	መልሲ	ኮድ	
501	እቲ ትካል ሓገዛዊ ዑደት ተጌሩሉ ይፈልጥ ዶ (ብ ወረዳ ጥዕና)	1. እወ 2. ኣይፋሉን	ናብ 506	
502	ክንደይ ግዜ ኣብ ዓመት	_____ ግዜ		
503	ግብረ መልሲ ሓገዛዊ ዑደት ብእዋኑ ይለአኽ ዶ	1. እወ 2. ኣይፋሉን 88. ኣይፈልጥን	ናብ 506 >>	
504	ዝተዋሃበ ግብረ መልሲ ንምምሕያሽ ስራሕቲ ትጥቐሙሉ ዶ	1. እወ 2. ኣይፋሉን	ናብ 506	
505	ንምንታይ ዘይትጥቀሙሉ	_____		
506	ኣብ ዝሓለፈ 6ተ ኣዋርሕ ካብ ክልል ጥዕና ቢሮ ሓገዛዊ ዑደት ተጌሩልኩም ይፈልጥዶ	1. እወ 2. ኣይፋሉን 88. ኣይፈልጥን	ናብ 508 >>	
507	እንትመፀ እንታይ ይሰርሑ	1. ናውትን ቀረብ መድሓኒት ይቐፃፀሩ 2. ስራሕቲ ምምሕዳር ይግምግሙ 3. ስራሕቲ ባዓል ሞያ ይግምግሙ 4. ካልእ		
508	ምምሕዳራዊ ሕቶታት እንተሃልዩ ናበይ ትኸይድ	1. ናብ ወረዳ ጥዕና ቤት ፅሕፈት 2. ናብ ቤት ፅሕፈት ሓላፊ 3. ናብ ክልል ጥዕና ቢሮ 4. ካልእ		
509	ሕቶ ናውቲ ሕክምናን መሳርሕታትን እንተሃልይካ ናበይ ትኸይድ	1. ናብ ወረዳ ጥዕና ቤት ፅሕፈት 2. ናብ ቤት ፅሕፈት ሓላፊ 3. ናብ ክልል ጥዕና ቢሮ 4. ካልእ		
510	ተገልገልቲ ንዝረኽብዎ ግለጋሎት ምጣነ ሰደራ ክፍሊት ይኸፍሉ ዶ	1. እወ 2. ኣይፋሉን		
511	ገምጋምስራሕቲ ይካየድ ዶ	1. እወ		

		2. አይፋሉን	ናብ ክፍሊ3	
512	ገምጋም ስራሕቲ ከመይ ይካየድ	1. ብቓል 2. ብፅሑፍ 3. ብክልቲኡ		
513	ገምጋምኩም እንታይ የጠቓልል	1. ሞያዊ ስራሕቲ 2. ምምሕዳራዊ ስራሕቲ 3. ክልቲኡ		

ክፍሊ 3 ኩነታት ስራሕ ቦታን ናውትን

ተቐ	ሕቶ	መልሲ	ኮድ	
601	ናይ ስራሕ ቦታኻ	1. እኹል ቦታ አለዎ 2. ንተገልገልቲ ምቹውነት 3. መብራህቲ አለዎ		
602	ንግልጋሎት ምጣነ ስድራ ዝውዕል እኹልን አገደስቲን ናውትን መሳርሕታትን አለውኹም ዶ	1. እወ 2. አይፋሉን	ናብ 604	
603	አይፋሉን እንተኾይኑ እንታይ ናውቲ ይኅድል	_____ _____ _____		
604	አብ ምጣነ ስድራ ዝዋሃብ ግልጋሎት የዕግበካ ድዩ	1. እወ 2. አይፋሉን		
605	አይፋሉን ተኾይኑ እንታይ ክማሓየሽ ትደሊ	_____		

ክፍሊ 4 ኩነታት ክእለትን ፍልጠትን

ተቐ	ሕቶ	መልሲ	ኮድ	
701	አብ ውሽጢ ዝሓለፈ ሓሙሽተ ዓመታት ስልጠና ገለጋሎት ምጣነ ስድራ ረኺብካ/ኪ ዶ	1. እወ 2. አይፋሉን	ናብ 705	
702	እንታይ ዓይነት ስልጠና	1. ምኽሪ ገልጋሎት ምጣነ ስድራ 2. አዋሃህባ አብ ማህፀን ዝአቱ መከላኸሊ ጥንሲ 3. አዋሃህባ አብ ኩርናዕ ዝቕበር ዓይነት መከላኸሊ ጥንሲ 4. ብ መጥባሕቲ ዝግበር ዓይነት መከላኸሊ ጥንሲ 5. ካልእ		
703	ዝወሰድ ካዮ ስልጠና አብ ተግባር አውዒልኪ/ካዮ ዶ	1. እወ 2. አይፋሉን	ናብ 705	
704	አይፋሉን ተኾይኑ ንምንታይ	_____		
705	አድለይቲ ዝኾኑ ስራሕቲ ምጣነ ስድራ ንምክያድ እኹል ፍልጠትን ክእለትን አለኒ ዶ ትብል/ሊ	1. እወ 2. አይፋሉን	ናብ 707	
706	አብ ምንታይ ዝተደረኸ ፍልጠትን ክእለትን ግልጋሎት ምጣነ ስድራ ስልጠና የድልየኒ እዩ ትብል/ሊ	_____ _____		
707	ግልጋሎት ምኽሪ ምጣነ ስድራ ሂብካ/ኪ ትፈልጥ/ጢ ዶ	1. እወ 2. አይፋሉን	ናብ 709	

708	አበየናይ ዓይነት መካላኸሊ ጥንሲ	1. ብአፍ ዝውሰድ መከላኸሊ ጥንሲ 2. ብመርፈእ ዝውሰድ መከላኸሊ ጥንሲ 3. አብ ማህፀን ዝአቱ (ሉፕ) 4. ኮንዶም 5. አብ ኩርናዕ ዝቕበር ዓይነት መከላኸሊ ጥንሲ 6. ምምካን ደቂ አንስትዮ 7. ምምካን ደቂ ተባዕትዮ 8. ካልእ		
709	እንታይ ዓይነት መከላኸሊ ጥነሲ ሂብካ/ኪ ትፈልጥ/ጢ	1. ብአፍ ዝውሰድ መከላኸሊ ጥንሲ 2. ብመርፈእ ዝውሰድ መከላኸሊ ጥንሲ 3. አብ ማህፀን ዝአቱ (ሉፕ) 4. ኮንዶም 5. አብ ኩርናዕ ዝቕበር ዓይነት መከላኸሊ ጥንሲ 6. ምምካን ደቂ አንስትዮ 7. ምምካን ደቂ ተባዕትዮ 8. ካልእ		
710	ተገልገልቲ አብ ትካልኩም ዘየለ ዓይነት መካላኸሊ እንተመሪያም እንታይ ትገብሩ	1. ናብ ዝላዓለ ትካል ይሰዳ 2. ካለእ ግዜ ክትምለስ ይሕብረላ 3. ካለእ መካላኸሊ ጥንሲ ይህባ 4. ካልእ		
711	አብ ትካልኩም ዘይዋሃብ ዓይነት መካላኸሊ ጥንሲ አየንኦም እዮም	_____ _____ _____ _____		
712	ብዛዕባ እዞም ዝስዕቡ መከላኸሊ ጥነሲ ዘለኪ/ካ ርእይቶ ግለፅ (ሪኢቶ) ምጣነ ስድራ)	1.አብ ማህፀን ዝአቱ (ሉፕ) _____ _____ 2. አብ ኩርናዕ ዝቕበር ዓይነት መከላኸሊ ጥንሲ _____ _____ 3. ምምካን ደቂ አንስትዮ 4. ምምካን ደቂ ተባዕትዮ		
713	ብስዳ ዖታዊ ርክብ ዝመፁ ከም ሕማም ኤድስ ዘአምሳሉ ኣብ ምክልኻልን ምክርንዘተከረ ሓበሬታ ትህቡ ዶ (ንተጠቀምቲ ምጣነ ሰድራ)	1. እዎ 2. አይፋላን		

ክፍሊ 5 ወዋሃበቲ ግልጋሎት አብ እዋን ስራሕ ዝግበር ምልከታ

ተቐ	ሕቶ	መልሲ	ኮድ	
801	ካብ ዝመረፀቶ ዓይነት መላኽሊ ብተወሳኺ ብዛዕባ እዞም ዝስዕቡ ዓይነት መካላኽሊ ጥንሲ ሓበሬታ ምሃብ _____	1. አብ ማህፀን ዝአቲ (ሉፕ) 2. አብ ኩርናዕ ዝቕበር ዓይነት መከላኽሊ ጥንሲ 3. ምምካን ደቂ አንስትዮ 4. ምምካን ደቂ ተባዕትዮ		

ሓ.ኩነታት ግልጋሎት እቲ ትካል

ተቐ	ሕቶ	መልሲ	ኮድ	
901	እዚ ትካል አብ ሰሙን ክንደይ መዓልቲ ግልጋሎት ምጣነ ስድራ ይህብ	_____ማዓልቲ		
902	ሓባሪ ግልጋሎት ምጣነ ስድራ አሎዶ	1. አብ ወፃኢ እቲ ትካል 2. አብ ውሽጢ እቲ ትካል 3. አብ ክልቲኡ 4. የለን		
903	በዝሒ ባዓል ሞያ አብ ግልጋሎት ምጣነ ስድራ ዝሰርሑ	1. ስፔሻሊስት 2. ጠቕላላ ሓኪም 3. መዋልዳን/ ነርስ መዋልዳን/ 4. ነርስ 5. ታሓጋጋዚ ነርስ		
904	እዞም ዝስዕቡ ናውቲ መምሃሪ ሓገዝ ምጣነ ስድራ አለውኹም ዶ	1. ፖስተር 2. ቻርት 3. ፋምፈሌት 4. መርአዪ ዓይነታት መከላኽሊ ጥነሲ 5. ሞዴል ስነ ቕርፂ		
905	ብዛዕባ ነዊሕን ቀወምትን ዓይነት መካላኽሊ ጥንሲ ሓ/ጥ/ ትምህርቲ ይዋሃብ ዶ (ፕሮግራም ሓ/ጥ/ት ተመልከት)	1. እወ 2. አይፋሉን		
906	አብ ዝሓለፉ 6ተ አዋረሕ ሕፅረት እዞም ዝወስዕቡ ዓይነት መከላኽሊ አጋጢሙ ዶ ነይሩ	1. ብአፍ ዝውሰድ መከላኽሊ ጥንሲ 2. ብመርፈእ ዝውሰድ መከላኽሊ ጥንሲ 3. አብ ማህፀን ዝአቲ (ሉፕ) 4. አብ ኩርናዕ ዝቕበር ዓይነት መከላኽሊ ጥንሲ 5. ካልእ		
907	አብ ትካልኩም አየናይ ዓይነት ግልጋሎት ይወሃብ	1. ብአፍ ዝውሰድ መከላኽሊ ጥንሲ 2. ብመርፈእ ዝውሰድ መከላኽሊ ጥንሲ 3. አብ ማህፀን ዝአቲ (ሉፕ) 4. ኮንዶም 5. አብ ኩርናዕ ዝቕበር ዓይነት መከላኽሊ ጥንሲ 6. ምምካን ደቂ አንስትዮ 7. ምምካን ደቂ ተባዕትዮ 8. ካልእ		
908	መቆፃፀሪ ፍሰት ናውቲ መከላኽሊ ጥንሲ አለኩም ዶ	1. እወ (ተመለከት) 2. አይፋሉን		
909	ዓይነት መከላኽሊ ጥንሲ ብቕደም	1. እወ (አረጋግፅ)		

	ሰዓብ እዋን ግልጋሎቶም ዶ ይቕመጡ	2. አይፋሉን					
910	መዓልታዊ ግለጋሎት ምጣነ ስደራ መመዝገቢ ቕጥዒ ወይ መዝገብ አለኩም ዶ	1. እወ (አረጋግፅ) 2. አይፋሉን					
911	ወርሓዊ ፀብፃብ ግልጋሎት መጣነ ስድራ ናብ ላዕለዋይ አካላት ሪፖርት ይግበር ዶ	1. እወ 2. አይፋሉን	በ 913				
912	ናይ ሪፖርት ግብረመልሲ ብእዋኑ ይመፀኩም ዶ	1. እወ 2. አይፋሉን 3. ሳሕቲ					
913	ፀብፃብ ዝሓለፈ 6ተ ወርሒ ብዓይነት መከላኸሊ ጥ ሲ						
		ፒል	ዲፖ	ሉፕ	ምምካን ደ/አ	ምምካን ደ/ተ	አብ ኩርናዕ ዝቕበር
	ጀመርቲ						
	ደገምቲ						
	ጠቕላላ						

<u>የቕንየለይ</u>

ANNEX 3: Declaration

The thesis my original work has not been presented for a degree in other university and that all sources of materials used for the thesis has been duly acknowledged.

Name: kidane Gebrekidan

Signature----------

Place: Department of community of health, Medical Faculity, Addis Ababa University

Date of submission----------

This thesis has been submitted for examination with my approvals as university advisor.

Name: Solomon Demamu (MD, MPH)

Signature----------