QUALITY OF FAMILY PLANNING COUNCELING AT POSTNATAL CARE AT ARMED FORCES COMPREHANSIVE SPECIALIZED HOSPITAL, ADDIS ABABA, ETHIOPIA

BY

YEMANE GEBREMESKEL BITEW

A THESIS SUBMMITTED TO CENTER FOR POPULATION STUDIES

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COLLEGE OF DEVELOPMENTAL STUDIES

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DECLARATION

This Thesis is my original work and has not been presented for a degree of masters in any other University and that all sources and materials used for the thesis have been duly acknowledged.

Declared by:

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As thesis research advisor, I hereby declare that I have read and evaluated this thesis prepared by under my supervision, by Yemane G/meskel Bitew : *Quality of Family Planning Counseling at Postnatal Care at Armed Forces Comprehensive Specialized Hospital, Addis Ababa, Ethiopia*. I recommend that this thesis work can be submitted as fulfilling the requirement for the Degree of Masters of Science in population studies.

Tariku Dejene(MSc)	_____	_____
Advisor	Signature	Date

This is to certify that Thesis prepared by Yemane G/meskel Bitew entitled: *Quality of Family Planning Counseling at Postnatal Care at Armed Forces Comprehensive Specialized Hospital, Addis Ababa, Ethiopia* and submitted in a partial fulfillment of the requirements for the Degree of Master of Science in Food Security and Development complies with the University and meets the accepted standards with respect to originality and quality.

Signed by the examining committee:

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Chairperson of the Center or Graduate Program Coordinator

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Abbreviations

CPR ---Contraceptive Prevalence Rate

DHS ---Demographic and Health Surveys

EC --- Emergency Contraceptive

FGAE ---Family Guidance Association of Ethiopia

ICE ----Information, Communication & Education

ICPD ----International Conference on Population & Development

ICU ---Intensive Care Unit

IUCD ---Intra- Uterine Contraceptive Device

IMR ----Infant Mortality Rate

IPPF ---International Planned Parent-hoods Federation

MCH ---Maternal & Child Heath

MII --- Method Information Index

PNC ---Post Natal Care

UNPF ---United Nations Population Fund

SDGs ---Sustainable Development Goals

Abstract

Family planning is one of the important key factors for development of the country especially for developing countries. So the main problem faced on good quality counseling on family planning is there is no proper quality counseling on family planning related to the contraceptive types availability &accessibility, the counseling given on the contraceptive they choice &other methods of contraceptive their use &side effects. Since there were no studies conducted in Armed Forces Comprehensive Specialized Hospital regarding quality of family planning services, this study was conducted with the objective of assessing the quality of family planning services at Armed Forces Comprehensive Specialized Hospital Addis Ababa, Ethiopia.

The methods which were used in this study were hospital based cross- sectional was conducted from October 2019- May 2020 G.C. Three hundred eighty four women were included in the hospital based study. For the assessment of availability of different family planning methods, technical service providers, and appropriate counseling of service providers on family planning.

Of the total respondents the majority, 149(38.8%) were using injectable and followed by pills, 121(31,5%). The remaining, 78(20.3%), 36(9.4%) were using IUD and implants respectively. Among the respondents 280(72. %) of them were not counseled for alternative contraceptive methods. The majority, 278(72.4%) had not been informed about the side effects and what to do if it occurs. 198(51.6%) of the respondents reported that they encountered health problems related to contraceptive method they were using.

Based on the logistic regression analysis factors that were associated with adequacy of family planning counseling sessions estimated monthly income, number of Pregnancy and side effect encountered were statistically significant associated with adequacy of family planning counseling sessions estimated monthly income, number of Pregnancy and side effect encountered were statistically significant. Adequate choice of contraceptives were not available and the information provided to the clients was insufficient.

CHAPTER ONE: INTRODUCTION

1.1. Back ground of the study

Family planning quality counseling service is one of the main targets for MCH in maternal mortality & IMR in Ethiopia. Consequently having good quality counseling in family planning service is very important in different Health institute. Good quality of care in family planning services help individual & coupled to meet their effectively. Therefore on assessment& improvement of the quality of family planning counseling service could enhance family Planning service utilization. Strengthening family planning services is crucial to improving health, human rights, economic development and slowing population growth 1.

Effective family planning is identified as one of the top ten public health achievements of the United States during the 20th century.2 However, an estimated 225 million women who want to avoid pregnancy are not using safe and effective family planning methods for various reasons including lack of access to information or services and lack of support from their partners or communities. The majority of these women with an unmet need for contraceptives live in 69 of the poorest countries. This unmet need is fueled by both growing population and a shortage of family planning services.3,4 In the last two decades, the contraceptive prevalence among married, reproductive-aged women has increased worldwide.

Globally, contraceptive prevalence rose from 55% in 1990 to 63% in 2010.5 However, the unmet need for contraception has remained high in developing regions.6 In 2013, only about a quarter of married women were practicing family planning in Africa.7 Increasing access to family planning services is widely recognized as a priority public health issue at an international level. A number of global partnerships, including the International Conference on Population and Development in 1994,8 the Millennium Development Goal summit in 20009 and the London Summit on Family Planning in 2012, endorsed a global partnership known as Family Planning 2020 aimed to enable 120 million more women to use contraceptives by 2020 in 69 of the world's poorest countries.10

Improving the quality of care in family planning services is known to be key to improving the use of family planning services in developing countries, both by attracting new contraceptive users and by maintaining existing users (i.e. ensuring continued engagement with services).11-

18 Providing decision makers in developing countries, including Africa, with the best available evidence on the factors that determine the quality of care in family planning services from the perspective of clients and health care providers is important to ensure the design and implementation of the most effective, efficient and acceptable quality improvement measures.

In this protocol and systematic review, family planning services is defined as the provision of counseling on contraceptive methods and/or provision of contraceptive methods including insertion of intrauterine devices, surgical sterilization services or prescription of contraceptive methods, in circumstances where the methods are not available.19-21

Improving quality of family planning services offers many benefits; information and service will be accessible, clients make informed decisions, and public will have a more positive view of health care and its providers. Good quality family planning service helps individuals and couples meet their reproductive health needs safely and effectively 1. Thus it could help to increase family planning users and it could contribute to control morbidity and mortality rate and unplanned population growth.

Studies in a number of countries indicated that wherever fertility is high, maternal, infant and child mortality rates are high too. In parts of Sub-Saharan Africa, there were more than 1,500 maternal deaths for every 100,000 live births; in USA this ratio was 12 deaths per 100,000 live births (3). Unsafe abortion is the cause for one in every four maternal death and in some countries as high as 50%(3). In Ethiopia, maternal mortality rate estimates the range between 500-1400 per100.000 live births (3,4). One out of seven in Ethiopia dies due to pregnancy & related causes, with more than 50% resulting from unsafe abortion, thus making Ethiopian women at reproductive health risk (5).

Rapid population growth has become the major threat facing the world today. Global population did not reach one billion until 1800; in mid 1992 it reached 5.5 billion. As the 20th century ends, UN demographers believed that the world population will total 6.2 billion (6,7). The population of less developed regions of the world including Africa, most of Asia, and Latin America is growing four times faster than the more developed Regions such as Europe, North America, and Australia. By the year 2025, world population may reach a hopping 8.5 billion (6). Unplanned population growth could have an effect on the environment and on people's quality of life.

Ethiopia is one of the most populous countries in Africa next to Nigeria . According to the 1994 census, the projected estimate for the year 2001 was 65.3-million with annual growth rate of 2.6 (8). The Ethiopian population growth is increasing alarmingly from year to year and it reached to 69,127,021 in 2002/03. Current population is estimated to be 110 million with the rate of natural increase 2.7% & total fertility rate of 5.9(9). If the population growth continues at this rate, it is expected to be double in less than 23 years (10). High Population growth rates put pressure on the already insufficient resources and pose a serious challenge to developing nations (11). For all the above reasons, provision of family planning Services has become the intervention of choice to slow the demographic explosions (12). It is also part of strategies to reduce the high rates of maternal, infant, child morbidity and mortality
(13).

The international Planned Parenthoods Federation (IPPF) has played a great role in the Expansion of family planning program worldwide. International Planned Parenthoods Federation Has adopted the concept of sexual and reproductive health agenda in its vision 2000. In 1994, the International Conference on Population and Development (ICPD) held in Cairo gave great attention to IPPF's reproductive and sexual health agenda. It emphasized peoples' right to reproductive health and the most important was quality service. Service should be accessible, acceptable, and convenient to all contraceptive users (14).

In addition to the role of clients' right, choice and consent had been strongly indorsed by most nations of the world through support of the program of action of the 1994 international conference on population and development (ICPD) in Cairo. These rights rest on the recognition of the basic rights of all couples and individuals to decide freely and responsibly the number, spacing, timing of their children and to have information and means to do so (15). The decision has to be made freely without any coercion, after the individual has been fully informed about the benefit of planning of family size, the methods one can use, the relative advantage and disadvantage of the method as well as the expected side effects of all the methods they are provided.

The need for family planning service in Ethiopia is evidenced by its population growth, morbidity and mortality statistics. Due to rapid population growth, systematic provision of family planning service had begun in 1966, when the Family Guidance Association of Ethiopia

(FGAE) was established as Non-Governmental, non-profitable organization by small group of concerned individuals (16).

In Ethiopia, there have been some efforts in family planning service to increase contraceptive prevalence rate. The Ethiopian population policy, which was adopted in 1993, has the objective of reducing the total fertility rate; as well as raising the contraceptive prevalence rate to a national coverage of 44% by the year 2015 (17). This effort was focused on expanding the service for previously uncovered areas by increasing the number of health institutions and other outlets. But still the Contraceptive Prevalence Rate is low (21.5%) (18). High fertility in Ethiopia is linked to both early marriage &low level of contraceptive use (19).

Family planning program alone in all circumstances cannot achieve the societal objectives of population stabilization. There must be a need to maintain the balance between availability and quality of service to improve family planning service utilization. Assessment of the 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). Recently, the idea of quality improvement has been used in managing health services, including those offered by Family planning Program (20).

Review of existing literatures strongly suggest that the quality of services provided are an important determinant of acceptance and continuation rates, and therefore a major contributor to increase in contraceptive prevalence rate (21). Despite the presence of family planning services, contraceptive prevalence rate is low in Ethiopia.

Therefore assessment of quality of family planning service at any level in our country is very important. Increasing quality of family planning service could help to sustain contraceptive use. This study may provide important information to family planning providers, policy makers, and program managers to improve quality of family planning service in the future. In this study, the framework of J.Bruce developed in 1990 will be used to guide the assessment of fundamental activities for describing the quality of care provided by a family planning program services in Armed forces comprehensive specialized Hospital Family planning services. This study will places particular emphasis on the interactions between provider and clients, because, these are seen as the key variables of service provision that influence the quality of care offered.

Therefore, this survey was intended to identify the quality of service provided at individual and service level by assessing such elements like waiting time, privacy, hours of opening time and so on. The study will try also to examine the availability and functionality of logistics and supplies at each family planning service delivery points.

1.2. Statement of the problem

Globally, contraceptive prevalence rose from 55% in 1990 to 63% in 2010.5 However, the unmet need for contraception has remained high in developing regions.6 In 2013, only about a quarter of married women were practicing family planning in Africa.7 Increasing access to family planning services is widely recognized as a priority public health issue at an international level. A number of global partnerships, including the International Conference on Population and Development in 1994,8 the Millennium Development Goal summit in 2000,9 and the London Summit on Family Planning in 2012, endorsed a global partnership known as Family Planning 2020 aimed to enable 120 million more women to use contraceptives by 2020 in 69 of the world's poorest countries.10

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In Ethiopia the level of maternal and infant morbidity and mortality are among the highest in the world. These attributed to, among other factors, none use of modern health care service by women in Ethiopia. According to 2005 Ethiopian demographic health survey more than seven in ten mothers did not receive ante natal care(12). Despite clearly demonstrated need for maternal health services, women often lack relevant information on essentials of antenatal care due to different reasons. To mention some: Health facilities are inaccessible, cost of transport is high, lack of time, shortage of human resources and content and quality is much lower in countries

with high mortality , in epidemiological study on association between availability and use of antennal services

It is also part of strategies to reduce the high rates of maternal, infant, child morbidity and mortality

(13).

The main problems in quality counseling in family planning are concept of counseling, not enough informed choice on contraceptive method and poor process quality. To solve the main problem training who are well skilled in quality counseling on contraceptive method to increase quality counseling in health facility so improving the good quality counseling. To increase the availability of provider informed choice on the contraceptive in different heath facilities.

So the sexual & reproductive health will be improved and the maternal infant mortality rate will be reduced so there will be maternal health improvement and child health so the healthy & productive citizen will be produced.

1.3. Objective of the study

1.3.1. General objective

The general objective of the study is to assess the quality of family planning counseling provided in postnatal care at Armed Force Comprehensive Specialized Hospital Addis Ababa, Ethiopia.

1.3.2. Specific Objective

Specifically this research plan is to:-

- ✓ Assess the quality of family planning provided by the provider
- ✓ Identify the determinant factors for quality counseling in family planning .

1.4. Significant of the study

This study has many significant matters on maternal & child health aspects especially in reproductive health .The situation which is given now on quality family planning counseling, the information communication& education system used, the different side effects encountered &where to go when side effects happen in addition the availability of contraceptive methods

given by the counselor the gaps will be identified &it gives a base for next strategies ,educational &gives special support for the population .The basic data concerning quality counseling on family planning are important for health policy planners health care providers, raise awareness in women of reproductive age group of 15-45& the public in general. More over to produce a healthy and productive generation this research will in no doubt serve as abases for future research. There is information communication and education gaps between policy planner and health care providers. The main recommendation for the gap the trained human power and give advises for stockholder to solve the gaps.

1.5. Scope and Limitation of the Study

The scope of the study is to determine Quality of Family Planning Counseling at Postnatal Care at the study area. The study was carried out among women attending postnatal clinic at Armed forces comprehensive specialty hospital in Addis Ababa and thus the research findings can only be applied to institutions with similar characteristics. The study was cross sectional and thus data collected does not show variation by seasons of the year. The study was carried out during covid-19 pandemic.

1.6. Organization of the paper

This paper is organized as follows into five chapters. Chapter two covers review of the literature which consists of theoretical, empirical, research gap and conceptual framework of the study. Description of the study area, research methodology, sampling procedure and ethical consideration is discussed in the third chapter. Chapter four, is about analysis, discussions and findings of the study which constitutes the main body of the document. Conclusions and recommendations are presented in the final chapter five. Finally, the reference materials and annexes are also included.

CHAPTER TWO: LITERATURE REVIEW

Effective family planning is identified as one of the top ten public health achievements of the United States during the 20th century.2 However, an estimated 225 million women who want to avoid pregnancy are not using safe and effective family planning methods for various reasons including lack of access to information or services and lack of support from their partners or communities. The majority of these women with an unmet need for contraceptives live in 69 of the poorest countries. This unmet need is fueled by both growing population and a shortage of family planning services.3,4 In the last two decades, the contraceptive prevalence among married, reproductive-aged women has increased worldwide.

Rapid population growth has become the major threat facing the world today. Global population did not reach one billion until 1800; in mid 1992 it reached 5.5 billion. As the 20th century ends, UN demographers believed that the world population was total 6.2 billion (6,7). The population of less developed regions of the world including Africa, most of Asia, and Latin America is growing four times faster than the more developed Regions such as Europe, North America, and Australia. By the year 2025, world population may reach a hopping 8.5 billion (6). Unplanned population growth could have an effect on the environment and on people's quality of life.

Good quality means "doing the right things right" (22). Quality in health care and family planning has been defined in many ways (23). From public health perspective, quality means offering the general health benefits, with the list health risk to the greater number of people, given the available resources. Also, good quality means either meeting minimal standards for adequate care or achieving high standards of excellence. Quality can refer to the technical quality of care to the non-technical aspect of service delivery such as clients' waiting time and staff attitudes, and to programmatic elements such as policies, infrastructures, access, and management (24, 25, 26). In health care and Family Planning Program service, this means offering a range of services that is safe, effective and that satisfy clients' needs and wants. Quality has different meaning to different people. Quality in this study is defined in terms of the way individual couples (clients) are treated by the family planning service delivery points.

A. Quality in terms of Provider perspective: - Historically, for the health care providers, quality has meant clinical quality of care offering technical competent, effective, safe care that contributes to an individual's well-being. For their part, program managers

recognize that support services for example logistics and records keeping also are important to quality of service delivery.

B. Quality in terms of Clients perspective: -Addressing clients' concern is as essential to good quality of care as technical competence. For clients, quality depends largely on their interaction with providers, such attributes as waiting time, privacy, and ease of access to care. The value of client's perspective on family planning service was increasingly recognized during the 1980th (27). A framework published by Judith Bruce in 1990, together with measurement and assessment tools developed by Anrudh Jain, has been especially influential in focusing attention on the clients' perspective (21, 24). How can we judge client's satisfaction in quality of family planning service? A growing body of research is discovering what clients want & how to measure client satisfaction. In both developed & developing countries, clients share seven major concerns (28,29). These are:

   Respect: -clients want to be treated with respect and friendliness.

   Understanding:- Clients value individualized service and prefer providers who make the effort to understanding their particular situation and needs.

   Complete and accurate information: -Clients value information. They worry that family planning providers are not telling them all facts, especially negative information about contraceptive methods.

   Technical competence: -Clients can and do judge the technical competence of the service they receive.

   Access: -Family planning clients want ready access to contraceptive service and supplies. Services have to be reliable, affordable, and without barriers.

   Fairness: - Clients want providers to offer thorough explanations and examinations to every one alike. They complain that providers offer preferential treatment to friends, relatives…etc.

   Results: -Clients come for service for a specific purpose. They are dissatisfied when told to come back another time or to go a different facility.

Quality of care as a factor that can inhibit the use of Family Planning services

Once a client reaches the service delivery point; his or her decision to adopt or sustain contraceptive use is influenced by the quality of care provided. The unmet need, which refers to

married women and unmarried adolescents who are sexually active may want to use contraception, but because of poor quality family planning service or expectation of poor service or some have been poorly treated at family planning clinic can keep them from using the service. Satisfied users will generate demand in the community and assist in the recruitment of additional accepters. Without significant attention to quality, it would be difficult to lower fertility rates through voluntary means (21). Studies in Peru showed that Contraceptive prevalence rate would be 16-23% greater in all women lived in cluster with the highest quality service compared with the lowest (37). The decision to initiate and continue to practice contraception may depend on the quality of care available to women, in particular the choice of methods provided, the information elicited for the women and communicated to her, and the nature of personal treatment given (38). Existing literature and analysis suggest that improvement in quality of family planning service by enhancing the choice of contraceptive methods available in a country would increase the overall practice of contraception and thus would result in fertility reduction (21).

Studies regarding status of quality of F/P service in Ethiopia are not carried out sufficiently. However studies in Jimma (38), showed that, 69(10.9%) and 14(8.1%) of those who reported problems expressed dissatisfaction with waiting time and solution given by providers respectively. Method unavailability was the reason in most services delivery points for providing methods different from client choice. In this study again provider's special training and time of training have shown significant difference on quality of indicators. Several constraints in the service provision of family planning were also identified (38).

Another study in A.A (39) has shown that shortage of logistics and supplies, poor client record, inadequate supervision, poor counseling service, and long waiting time were major constraints to satisfy clients. These and other studies in developing countries showed that, the presence of low quality of family planning service contribute to lessened service utilization (21,38). Assessment of the 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.

Evaluating Quality of Contraceptive Counseling: An Analysis of the Method Information Index Karen T. Chang , Mulenga Mukanu , Ben Bellows , Waqas Hameed , Amanda M. Kalamar , Karen A. Grépin , Xaher Gul , and Nirali M. Chakraborty The Method Information Index (MII)

is calculated from contraceptive users' responses to questions regarding counseling content—whether they were informed about methods other than the one they received, told about method specific side effects, and advised what to do if they experienced side effects. The MII is increasingly reported in national surveys and used to track program performance, but little is known about its properties.

Using additional questions, we assessed the consistency between responses and the method received in a prospective, multi-country study. We employed two definitions of consistency: (1) presence of any concordant response, and (2) absence of discordant responses. Consistency was high when asking whether users were informed about other methods and what to do about side effects. Responses were least consistent when asking whether side effects were mentioned. Adjusting for inconsistency, scores were up to 50 percent and 30 percent lower in Pakistan and Uganda, respectively, compared to unadjusted MII scores. Additional questions facilitated better understanding of counseling quality. The renewed focus on quality of care in the era of sustainable development goals (SDGs) has accelerated efforts to define and develop measures of service quality (Leisher et al. 2015; Kruk, Pate, and Mullen 2017). The Method Information Index (MII) is a relatively new entrant into the suite of family planning (FP) quality indicators. It can be thought of as one way to assess the "information given to clients" element of the well-established quality of care framework put forth by Judith Bruce (1990).

The purpose of making sure that the client receives complete information about her method is both to ensure informed choice as well as contraceptive continuation. It is also a way to assess that women's evaluating Quality of Contraceptive Counseling care is consistent with their reproductive rights, specifically the right to sexual and reproductive health (SRH) services, information, and education as described by Erdman and Cook (2008).

Counseling women appropriately with instructions that they understand preserves their rights to information as well as reproductive self-determination (Hardee et al. 2014). Assessments of counseling have traditionally been done either through direct observation, exit interview, or retrospective report by the FP user. In the absence of direct observation of the client-provider interaction, asking women about the information they received is used as a proxy indicator of the quality of the services provided (Bessinger and Bertrand 2001; Chin-Quee, Janowitz, and Otterness 2007). When used in this way, the MII can be reported at the provider, clinic, or

program level as an indicator of program performance. When used as a component of a population-based survey, as done in the Demographic and Health Surveys (DHS) Women's Questionnaire or the Performance Monitoring and Accountability 2020 (PMA2020) surveys, the MII can be reported at a national or international level and allows for comparison across countries and over time, making it an extremely versatile indicator. The MII has also been adopted as one of the core indicators for the Family Planning 2020 (FP2020) initiative. It is the only indicator that addresses the concepts of counseling, informed choice, and process quality. The use of client perspectives has been emphasized as an important aspect of evaluating service quality (Donabedian 1988; Calnan 1998; Williams 1998). Although clients' views are subjective, prone to measurement error, and may differ from providers' perspective of quality (Petersen 1988), they are insightful for service providers and programmers to understand clients' perception of service quality (Andaleeb 2001).

In nationally representative surveys, the MII is calculated from current contraceptive users' responses to three input questions about the information providers gave when they received their current method: whether they were informed about other methods aside from their current method, told about possible side effects from their current method, and advised what to do if they experienced side effects (ICF International 2015). For each of these questions, responses are coded 1 if the respondent answered "yes" or 0 otherwise, and the reported index score is the percent of women who responded "yes" to all three questions. Comprised of only three binary questions, the MII is simple and relatively easy to collect. However, how well it reflects client understanding of counseling information has not yet been demonstrated.

With its increased use, comparing the MII with other data of client understanding may help to build greater confidence in this indicator. Both a 2016 United Nations Population Fund (UNFPA) study of informed choice in 24 countries and a 2016 comparison of two rounds of DHS datasets in 25 countries identified a great deal of variability in the MII and informed choice between countries and over time (Jain 2016; Loaiza, Liang, and Snow 2016). Jain (2016) noted that MII scores on average increased between two time points (34–39 percent), suggesting counseling quality had improved over time. Jain (2016) also described high variation in the proportion of women between measures of FP service quality at the facility level, client-reported MII at baseline exit interviews, and 12-month all-method contraceptive discontinuation, we

performed an analysis of baseline client-level data to assess the consistency between responses to additional questions about specific information exchanged and the FP method received. Receiving all three pieces of information, both across countries and within a given country by method, household wealth, and respondent education. This suggests good quality counseling is not consistently delivered across settings and populations. Furthermore, little is known about the specific content of information exchanged between a provider and a client (Jain 2016). The MII alone does not demonstrate whether a client leaves her visit with a complete Studies in Family Planning 50(1) March 2019 Chang et al. 27 understanding of what to expect with her method. The successful transfer of counseling information may be important for a client's willingness to accept any side effects and her continued contraceptive use. As part of a broader longitudinal study in Uganda and Pakistan to assess correlations

2.1. Benefit of good quality

Assuring the good quality of service is an ethical obligation of health care providers (30). Research is beginning to show that good quality also offers practical benefits to family planning clients and programs (30). These include: -

1. Safety and effectiveness: -Good qualities make contraception safer and more effective. If poorly delivered, some family planning service can cause infection, injuries, and in rare cases death. Poor services also can lead to incorrect, inconsistent, or discontinued contraceptive use (31). Good quality family planning is effective, because, it helps to inform clients fully; screen clients for medical eligibility, clients choose for the methods that suit their individual circumstances, teach clients how to use their methods properly, and support clients when they encounter problems or decide to switch methods.
2. Greater client satisfaction and continuation: Good cares attract, satisfy, and keep clients by offering them the service, supplies, information, and emotional support they need to meet their individual goals. Studies found that good service encourage people to continue using contraception when they want to avoid pregnancy. For example in China, women were far more likely to continue using injectable contraception when they had been thoroughly counseled on how the method works and its side effects. Only 11% of women receiving good counseling had

dropped out at one year compared with 42% of women receiving limited counseling (32). In Bangladesh, rural women were asked whether the field worker serving them was responsive, sensitive to their need for privacy, sympathetic, and informative. Women, who felt they received good care, as judged by their answer to the questions, were 27% more likely to continue using a method and 72% more likely to continue using a method for up to two months than women who felt they had received poor care (33).

3. Wider use of contraception: -Clients use contraception with various specific aspects of quality of care, including the thoroughness of counseling, receiving one's preferred method, and availability of services (31, 34).
4. More job satisfaction to providers: -Providers derive greater personal and professional satisfaction from their job when they can offer good quality of care and can feel their work is valuable. For example, project that empowered health care workers' to develop their own solutions to local problems reduce workers' absenteeism in Uganda (35).
5. Ensuring access to service: -Quality family planning service is closely linked to accessibility.

2.2. Theoretical framework

In 1994 the international conference on population &development In Cairo adopted a human right approach in declaring family planning a core parts of reproductive health while emphasizing the importance of quality in family planning service and cares despite the consensus reached at the conference family planning remained in the shadow of other global health challenges. A barrier to increased access to family planning& contraception includes and are not limited to restrictive religious &cultural norms. Level of education, access to health care & poor quality of family planning service encompasses facility level structural components such as the availability of services &contraception methods & components related to the client such as privacy during consultation & information received during family planning counseling. The role of counseling in family planning is to support women in navigating the process of choosing a contraceptive method that will allow her to fulfill her family planning goals & exercise her

reproductive health rights. Clients must be appropriately informed about the contraceptive methods available to them &understand their efficacy side effects & management. The decision for a client to use contraception should ultimately be driven by the exposure to proper information to make an informed choice free from coercion.

Different aspects of quality of family planning service have been a focus of studies since its determination as an important component of contraception use & or continuation with women who reported having experienced higher quality of care have a higher rate of contraceptive use & continuation. A study across 15 sub Saharan countries found that within one year of starting a contraceptive method 7-27% of women ceased to use contraceptive for reasons related to the information received &confusion about side effects. The evidence from studies also indicates that the provision of information on side –effect is associated with improved contraception use outcome .it is therefore imperative to provide high quality counseling that fosters the provision of proper information about family planning& contraception to clients.

The quality of structures components of family planning service in public facility (i.e. no of methods availability distance of facility) has been identified as an important factor in the adoption of modern contraception use in Ethiopia. Nevertheless studies have suggested that the quality & coverage of family planning counseling remains low in Ethiopia. A study set in a prenatal care clinic in Gondar, Ethiopia showed that only 34.8% of patients were counseled on family planning. Another study found that the technical quality of family planning measured by the average score of the observed recommended clinical actions conducted during family planning consultations was low at the national level with 24 recommended clinical steps provided only one third of the time.

Despite studies focusing on the quality of family planning service in Ethiopia they don't capture quality from the clients perspective on information received during counseling. Assessment of counseling concerning a client's perspective have traditionally been done either through direct observation, exit interview or retrospective reports by family planning clients. Asking women about the information they received can be used as a proxy for the quality of the service provided & nationally representative surveys make it possible to study individual response data that can, in turn, shed light on quality from the client's perspective. The method information index (MII), a core indicator of the family planning 2020 initiative. Providers insight into the quality of family

planning counseling &reflects the extent to which women are informed about side –effect and alternative methods.it is calculated from contraceptive user responses to three questions pertaining to the information they were given at the time they selected their contraceptive method. The reported value or" score" is the percent of women who responded "yes" to all three questions &held the assumption that essential information on family planning & contraception was provided during counseling.

2.3. Empirical framework

Quality family planning counseling on the ground is very important for improving reproductive health by increasing family panning client uses for continues use of the service.by using method information index it will assess the conditions& the gab finding in broad scope of the research .to know the gab which is found from the research and to put important ideas for planning & strategies for national level and to increase the family planning followers to have best solution for the problem of the clients.

Empirical studies have shown facility-related factors such as managing authority (public or privately owned), availability of a variety of methods and waiting time 21,26-29 as being associated with quality of care in family planning services. Client-related factors such as age, educational status and client types (new versus repeat)30,32 have also been identified in the existing empirical research as associated with quality of care in family planning services. In addition, provider-related characteristics such as sex, year of experience and level of education have been identified as factors associated with the quality of care in family planning services 31, 32. Overall, the findings indicate that there are no consistent results across studies.

The cursory search of the literature undertaken to inform this protocol identified three systematic reviews addressing the question of quality of care in family planning service and its determinants. All three included only studies conducted in the United States 31,33,34 The preliminary literature search identified six primary studies19,21,30,35-37 conducted in Africa examining the determinants of quality of care in family planning services. Two of the studies used qualitative method35,37 and four used quantitative methods.19,21,30,36 Two studies were conducted in Ethiopia,30,36 one in Kenya,35 one in Uganda37 and two studies19,21 were undertaken in various other African countries. No systematic review of the quantitative,

qualitative evidence, or both, on the factors determining quality of care in family planning services in any African countries was identified.

2.4. Conceptual framework

Initial searching of the literature relating to quality of care in family planning services in Africa, low- and middle-income countries and the rest of the world revealed that researchers have used various approaches to define and measure quality of care in family planning services. The definition and measurement of quality of care might vary based on the stakeholders' priorities and various perspectives. The Donabedian model and Bruce Framework have been the most frequently used approaches, at least since 1990, to inform studies assessing and describing the quality of family planning services.

Donabedian defined quality of care as "the application of medical science and technology in a manner that maximizes the benefits to health without correspondingly increasing the risk".23(p.5). This model is intended to assess quality of care in various health services including family planning. He identified quality of care as a linear model comprising the three components structure, process and outcome. The structure dimension includes all factors affecting the conditions of care such as budget, staff training, reward systems, payment methods, facilities and equipment. The process dimension focuses on the provider's communication with the client including the client-provider relationship. The last component is the outcome following provider and client interaction in the healthcare delivery site. This includes the client's satisfaction, change in knowledge and other subsequent long-term aspects such as reduction in fertility and mortality. These three parts are interlinked in the model, with good structure presented as increasing the likelihood of good process and good process as increasing the likelihood of a good outcome.23,24

Based on the Donabedian model, Bruce and Jain developed a framework assessing the quality of care in family planning services. They identified six elements for quality of care in family planning programs that they propose to "reflect the six aspects of services that clients experience as critical". These six elements form the Bruce Jain Framework for assessing quality of care in family planning. The elements are (1) choice of methods, (2) information given to clients, (3) technical competence of providers, (4) interpersonal relations, (5) follow-up mechanisms and (6) appropriate constellation of services.25

The "Choice of Methods" refers to having a range of contraceptive methods offered to the clients considering their diverse needs influenced by age, gender, contraceptive intention, lactation status, health profile and wealth status. "Information given to clients" refers to the information provided to clients during service interactions that enables clients to choose and use contraception with competence and satisfaction. This includes information about a range of available contraceptive methods, method contraindications, method advantages and disadvantages, how to use the selected method, potential side effects and continuing care from service providers. The "Technical Competence" aspect involves providers' clinical techniques, use of protocols and implemention of aseptic procedures in clinical conditions. "Interpersonal relations" refers to the degree of empathy, trust, assurance of confidentiality and sensitivity of providers to meet the client's needs and expectations. The "Follow-up Mechanism" covers how service providers encourage clients on the continuity of use through well informed mechanisms such as community mass media, client-based follow-up mechanisms (return appointments) or home visits. The last component, "Appropriate Constellation of Services", refers to the extent to which family planning services are situated in convenient and accessible locations. This includes their accessibility (distance, timing and cost) and the level of integration with other reproductive and maternal health services.

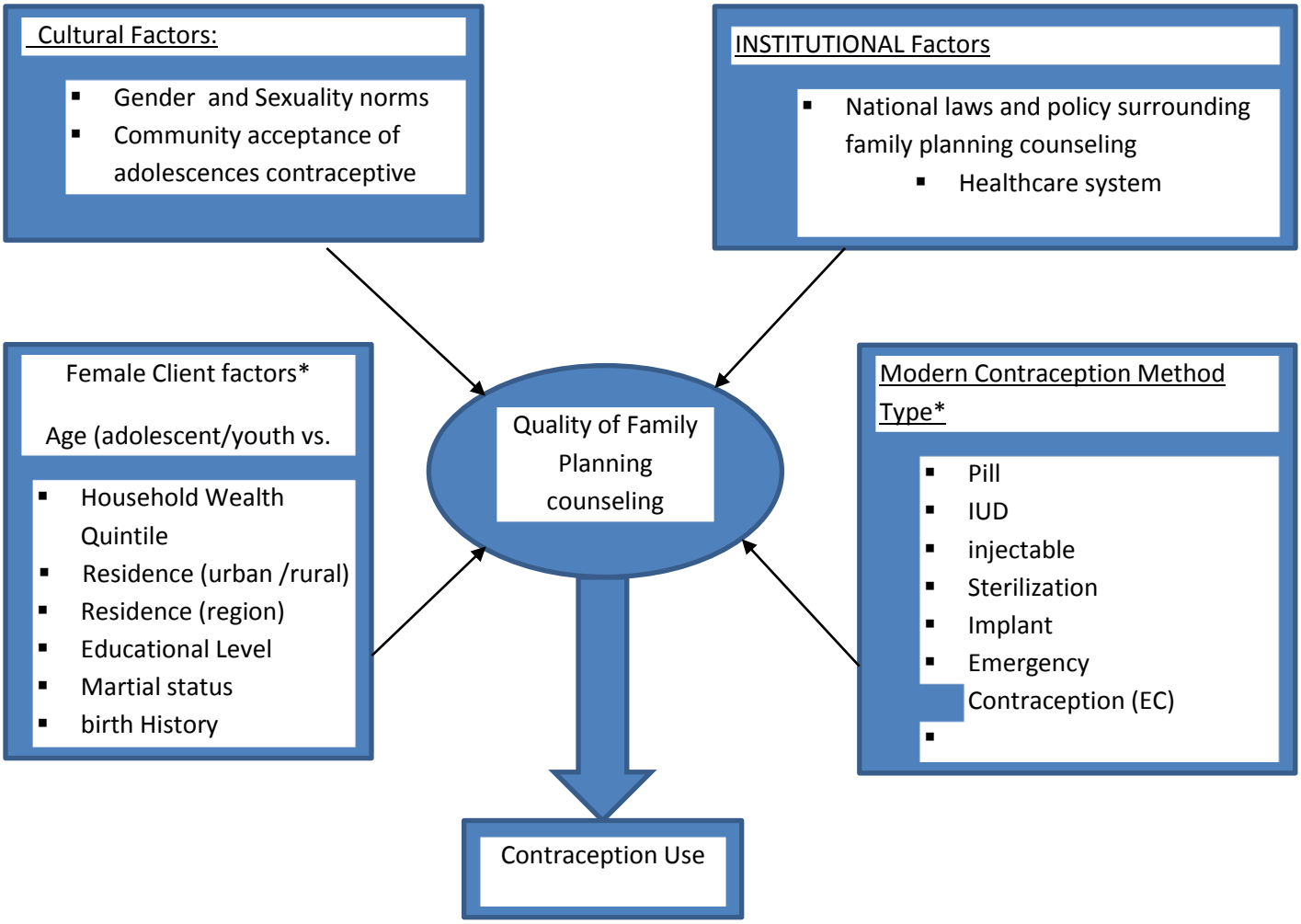

Figure 1 : Conceptual frame work from plos/one2020

Ensuring access to service means, making good quality, affordable care available where and when convenient to public. When a facility lacks properly trained staff, opens irregularly, suffers from supply shortages, charge high prices, or blocks care with unnecessary medical barriers, the community does not have adequate access to service (36).

CHAPTER THREE: DESCRIPTION OF THE STUDY AREA AND THE RESEARCH METHODS

3.1. Description of the institution (study area)

Addis Ababa is the capital city of Ethiopia. Currently based on the 2007 census conducted by Central Statics Agency of Ethiopia (CSA) Addis Ababa has a total population of 3,384,569 according to census 2007. However it's believed that this number was inaccurate when recorded under estimated the city's population. The city has through recent years seen a robust annual growth rate and population counts has of 2017 are growing closer 4 million. All of the populations are urban in habitants. The total number of Hospitals in Addis Ababa city is 41 Health indicators, (FMOH; EFY, 2001) out of the total 41 hospitals, about 10 of them are public, the rest, about 31 hospitals, are run by private investors and non-profit organizations. This research is selected to be carried out at Armed Forces comprehensive specialized Hospital. The hospital is found in lideta sub-city which is one of the 10 sub-cities in Addis Ababa. In this sub-city there are two governmental and 5 non-governmental hospitals. As of 2019 its population were 214,496 from this 102,513 are male and 112,283 are female, (CSA, August, 2019). The district is located in the central-western area of the city, nearby the centre. It borders with the districts of Addis Ketema, Arada, Kirkos, kolfe-keraniyo and nifas silk-lafto sub-city. The hospital which is formerly, known as Princess Tsehay Memorial Hospital founded by Emperor Haile Selassie in memory of his daughter. She died of illness in 1942. AFCSH got its current name after the 1974 revolution. It is owned by the government under the federal Minster of Defense which is situated at western part Addis Ababa and other regional hospitals are under Minster of Defense. It gives regular health services for army, their family member's and civilian members of the defense inpatients and ambulatory patients. The hospitals have facilities of integrated modern maternal and child health service well skilled professional nurses and specialist in Gynecology and obstetrics department. The hospital facility have different departments like Emergency Room, Surgical, medical, Intensive Care Unit (ICU),Pediatric and Maternity wards, Laboratory, Radiology, Anesthesiology, Pathology, oncology and Rehabilitation center with covid-19 services.

3.2. Study design

Institutional based cross sectional study design was used to assess the quality of family planning and counseling at Armed Forces Comprehensive Specialized Hospital. It used quantitative research approach. Quantitative research methods were used to provide the major connection between empirical observation and scientific expression of variables under the survey and computed the result through statistically summary or analysis. The survey was conducted from October 2019 to May, 2020.

3.3. Study variables

There were two variables in the study

3.3.1. Dependent Variable

Quality of counseling and family planning among woman of reproductive age group from15-45 years.

3.3.2. Independent Variable

The independent variable will be woman of reproductive age 15-45 years, socio demographic characteristics such as :- Age, marital status, family history, gr-avidity, Number of abortions, Number of still births, educational status, socio-economies characteristic like occupation and income.

3.3.3. Operational Definitions

Quality Family planning counseling:-The provision of information and assistance in a choosing a method that meets a Women needs and preferences.

Adequate knowledge: If a mother answered at least eight of the eleven knowledge assessment questions correctly.

Inadequate knowledge: If a mother answered below six of the eleven knowledge assessment questions.

3.4. Data sources

The data was collected from primary data sources which were collected from the sample respondents through questioner. And also data was collected from statistical report like CSA, EDHS and official world wide websites like WHO, FAO, MoH official websites.

3.4.1. Source population

All women who attending post natal clinic visit in Armed Force Comprehensive specialized Hospital Addis Ababa, Ethiopia.

3.4.2. Study population

All woman in reproductive age group from 15-49 years old who visit post natal clinic for family planning services in regular Bases of Armed force Comprehensive specialized Hospital at the time of study period in Addis Ababa, Ethiopia.

3.5. Inclusion and exclusion criteria

3.5.1. Inclusion criteria

Woman in reproductive age group from 15-49 years old who visit post natal clinic for family planning services of Armed force Comprehensive specialized Hospital at the time of study period were included in the study.

3.5.2. Exclusion criteria

Individuals who are an able to give response due to series physical or mental illness & with whom they are in Obstetric emergency condition & not consented was excluded from the study.

3.6. Sample size determination, sampling techniques and procedures

3.6.1. Sample size determination

The sample size was calculated by using single population proportion formula by considering quality family planning counseling about population $n = [(Z\alpha/2)2\ p\ (1-p)]$ by having 50% using the formula n =384

3.7. Tools of data collection

3.7.1. Questioner

Structural interview question were used to meet the aim of study based on the literature review & will be written simple English & Amharic languages to suit the participants level of understanding Socio demographic exotic was collected as, marital status, residence educational level. Health behaviors, gravidity, parity, No of stillbirth, type of contraception chosen, level of income, type of contraceptive methods available & chosen, type of contraceptive method will be listed & quality counseling on each types, it's a side effect & what to do whom & where to go if develop the side effect.

3.8. Data processing and analysis

Data generated was entered in to micro-soft Excel sprees sheet 2010 (Microsoft corp. USA). The data was imp perfected from Microsoft Excel spread sheet & analyses by statically package for service (SPSS) software version 21 (IBM USA) description statics will completed & data will be presented using Figure and tables & binary logistic regression will be used to show the association of different variables with the dependent variable. Moreover a multiple variable analysis was done to identify the factors that are independently associated p-value less than 0.05 were considered significant in analysis.

3.8.1. Data quality assurance

Prior to the data collection, training was provided to data collection & the questionnaire was pre-tested to assure that it is proper and understandable. It was revised by supervisor and the recommended modifications to specific items data was done to the study objectives and also during actual data collection. The collected data was checked daily for reliability and completeness.

3.9. Ethical Consideration

Permission was acquired from the graduate school of AAU and approval to carry out the research was granted. Ethical clearance was obtained from Armed Forces Comprehensive Specialty Hospital. The questionnaires administered to the respondents upon obtaining an informed written or thumb print consent. Before consent was obtained, the researcher and the research assistants explained the purpose of the study and respondents were assured of

confidentiality of the information they give then require their permission. To ensure privacy, names and other means of identity was not used during the data collection. The researcher ensured that all information obtained will be kept in strict confidence and will be used only for the purpose of the study.

CHAPTER FOUR: RESULTS

4.1. Socio-demographic characteristics of respondents

A total of 384 women responded to the questionnaires providing a response rate of 100%. The majority of the study subjects, 148(38.5%) and 146(38) were in the age ranges 25 - 29 and 30 - 34 respectively. The remaining, 56(14.4%), 32(8.3%), 2(%) were in the age ranges of <=24, 35 – 39 and >=40 years respectively. Majority of 222(57.8%) were married, 146(38%) divorced, the remaining 10(2.6%), and 6(1.6%) were single and widowed respectively. The majority 205(53.4%), and 144(37.5%) were completed secondary and primary schools and few of them, 23(6%) and 12(3.1%) were above secondary and none educated correspondingly. When religious affiliation is considered, the majority, 161(41.9%) were Muslim followed by Catholic accounts 112(28.6%). The remaining, 54(14.1%), 35(9.1%) and others 24, (6,3%) were Orthodox, and others correspondingly. Regarding to occupation, the majority, 131(34.1%) were unemployed, 108(28,1%) were housewives. The remaining, 83(21.6%), 56(14.6%), 6(1.6%) were government employee, self-employed, and daily laborer respectively. As to the data related to monthly income, most of the respondents, 122(32%) were earning less than or equal to 1000 birr followed by 115(30%) of them were getting 2501 to 4500 birr. The remaining, 88(23%) were earning 1000 to 2500 birr on monthly bases. The majority of the respondents 333(86.7%) were urban dwellers, while few 51(13.3%) were from rural areas.

Table 1: Socio-Demographic factors among postnatal women attended Armed Force specialized Hospital FP unit from October 2019 to May, 2020, Addis Ababa

Age of Respondents	Frequency	Percent	Cumulative Percent
<= -24	56	14.6	14.6
25-29	148	38.5	53.1
30-34	146	38.0	91.1
35-39	32	8.3	99.5
>=40	2	.5	100.0
Total	**384**	**100.0**	
Marital Status			
Single	10	2.6	2.6
Married	222	57.8	60.4
Divorced	146	38.0	98.4
Widowed	6	1.6	100.0
Total	384	100.0	
Educational Status			
no education	12	3.1	3.1
Primary	144	37.5	40.6
Secondary	205	53.4	94.0
above secondary	23	6.0	100.0
Total	384	100	
Religious status			
Orthodox	54	14.1	14.1
Muslim	161	41.9	56.0
Catholic	110	28.6	84.6
Traditional	35	9.1	93.8
Others	24	6.3	100.0
Total	384	100.0	
Occupational Status			
housewife	108	28.1	28.1
government employee	83	21.6	49.7
self employed	56	14.6	64.3
daily laborer	6	1.6	65.9
unemployed	131	34.1	100.0
Total	384	100.0	

Table 2: Socio-demographic continued……

Monthly income			
<=1000	122	32	32
1001-2500	59	15	37
2501-4500	115	30	67
4501-6500	88	23	100
>6500	0	0	0
Total	384	100	
Place of residence			
Urban	333	86.7	86.7
Rural	51	13.3	100.0
Total	384	100.0	

4.2. Reproductive and Child health history:

Concerning to reproductive history of the respondents, the majority, 330(86%) had 1-2 born alive children and few 54(14%) had 3-4 born alive children. They have reported that the same number and percentage had alive children.

Table 3: Reproductive and Child Birth

# of live birth	Frequency	Percent	Cumulative percent
1-2	330	86	86
3-4	54	14	14
>4	0	0	100
Total	384		
#of children alive now			
1-2	330	86	86
3-4	54	14	100
>4	0	0	100
Total	384	100	

4.3. Family planning service utilization and services rendered

Of the total respondents the majority, 149(38.8%) were using inject-able and followed by pills, 121(31,5%). The remaining, 78(20.3%), 36(9.4%) were using IUCD and implants respectively. Among the respondents only 104(27.1%) were told about alternative contraceptive method but the majority, 280(72. %) of them were not counseled for alternative contraceptive methods. Only 106(27.6%) of the subjects were told about the common side effects of contraceptive method they were using but the majority, 278(72.4%) had not been informed about the side effects and what to do if it occurs. 198(51.6%) of the respondents reported that they encountered health problems related to contraceptive method they were using and 186(48.1%) didn't. Against the inquiry for the availability of contraceptive methods, 351(91.4%) of the respondents said that it was enough and the remaining 32(8.3%) said it was not enough. Relating to the preference of contraceptive methods the majority, 163(42.4%) were preferring oral pills followed by injectables,115(29.9%). The remaining, 71(18.5%). 35(9.1%) were preferring IUCD and Norplant respectively. When questioned about the sources of information about contraceptive methods, 162(42.2%) of the respondents got from health personnel. The rest 106(27.1%), 83(21.7%) and 33(8.6%) of them acquired from friends, mass media, and others respectively. Almost all 373(97.1%) of the subjects said that they have got new idea about reproductive health from the service givers and only few, 11(2.9%) didn't.

The three questions that were used for assessing the method information index were: - Counseled on alternative contraceptives, informed side effects chosen method and told what to do if side effects were occur.

Table 4: Family planning Service Utilization and Services given

Contraceptive methods currently using	**Frequency**	**percentage**	**Cumulative**
Pills	121	31.5	31.5
Injectable	149	38.8	70.3
IUD	78	20.3	90.6
Implant	36	9.4	100.0
Total	384	100.0	
Counselled on alternative contraceptives			
Yes	104	27.1	27.1
No	280	72.9	100.0
Total	384	100.0	
Informed side effects chosen method	Frequency	Percent	Cumulative Percent
Yes	106	27.6	27.6
No	278	72.4	100.0
Total	384	100.0	
Told what to do if side effects were occur	Frequency	Percent	Cumulative Percent
Yes	107	27.9	27.9
No	277	72.1	100.0
Total	384	100.0	
Have you ever been encountered problems related to contraceptive use			
Yes	198	51.6	51.6
No	186	48.4	100.0
Total	384	100.0	
Availability of contraceptive methods			
Enough	351	91.4	91.4
not enough	32	8.3	99.7
not available	1	.3	100.0
Total	384	100.0	

Table 5: Family planning cont'd

Which contraceptive method did you decided to take?			
Oral Pill	163	42.4	42.4
Injectable	115	29.9	72.4
IUCD	71	18.5	90.9
Norplant	35	9.1	100.0
Total	384	100.0	
From where do you get information about family planning?			
Friend	106	27.6	27.6
Health worker	162	42.2	69.8
Mass media	83	21.6	91.4
Others	33	8.6	100.0
Total	384	100.0	
Have you got a new idea about reproductive health from the counselor?			
Yes	373	97.1	97.1
No	11	2.9	100.0
Total	384	100.0	
Knowledge about the acceptance of adolescent family planning			
Enough	380	99.0	
not enough	4	1.0	
Total	384	100.0	
Where do you obtain (current contraceptive method) the last time?			
Public	358	93.2	93.2
Private	26	6.8	100.0
Total	384	100.0	

4.4. Investigator's Observations

Concerning the categories of service providers, most of the clients, 240(62.5%) were midwives followed by nurses, 83(21.6%). The remaining were, 34(8.9%), and 27(7%) were doctors and gynecologists. The activities of the providers were supervised when they were providing the services for 374(97.4%) of the clients and found that 170(44.3%), 180(46.9%) and 34(8.9%) had very good, good and fair interpersonal skills and technical competencies. The providers were found using infection control guide line during their contact with 370(96.4%) of the clients and were not for 14(3.6%) of them. The hospital environment was attractive and clean during the time of investigation.

Table 6: Investigator's observations

What is the providers category?			
Mid wife	240	62.5	62.5
Nurse	83	21.6	84.1
Doctor	34	8.9	93.0
Gynecologist	27	7.0	100.0
Total	384	100.0	
Was the providers activity supervised?			
Yes	374	97.4	97.4
No	10	2.6	100.0
Total	384	100.0	
The interpersonal skill and technical competence of the provider is?			
Very good	170	44.3	44.3
Good	180	46.9	91.1
Fair	34	8.9	100.0
Total	384	100.0	
Was the provider using infection control guide line appropriately?			
Yes	370	96.4	96.4
No	14	3.6	100.0
Total	384	100.0	
Was the hospital environment attractive and clean?			
Yes	339	88.3	88.3
No	45	11.7	100.0
Total	384	100.0	

4.5. Factors associated with adequacy of family planning counseling sessions as measure of quality of Service

Only 159 (41.1%) of the counseling sessions were adequate, while 225 (58.1%) were inadequate. Variables such as the socio-demographic characteristics of the clients (such average estimated income, place of residence, and reproductive history, use of family planning services) were entered into bivariate analysis. The estimated income of the clients was statistically associated with the level of family planning counseling. Clients having estimated average monthly income of Eth. Birr 1001-2500 (COR =8.961, 95%, CI = 2.823-2.845) were more likely to report inadequate counseling sessions. Similarly, clients with frequency of pregnancy 1 to 2 (COR =2.170, 95%, CI = 7.389-8.372) were more likely to report inadequate counseling session. In the other way, clients who had encountered side effects of contraceptive methods they were using ((COR =2.194, 95%, CI = 1.330-3.617) found more likely report inadequacy of counseling session.

Table7: Factors associated with adequacy of family planning counseling sessions

Descriptions income	**Adequate #(%)**	**Inadequate #(%)**	**COR with 95% CI**
Estimated monthly income			
<=1000	48(13)	77(20)	1.275(2.275-7.143)
1001-2500	72(20)	36(9)	8.961(2.823-2.845)*
2501-4500	33(9)	54(14)	4.851(1.993-1.28)
4501-6500	40(10)	24(15)	1
>6500	0	0	
Total	**193**	**191**	
Number of Pregnancy			
1-2	41(11)	65(17)	2.170(7.389-8.372)*
2-3	91(24)	133(35)	2.904(1.334-6.372)
>=3	27(7)	27(7.0)	1
Total	**159**	**225**	
Side effect encountered			
Yes	96(25)	63(16)	2.194(1.330-3.617)*
No	102(27)	123(32)	1
Total			

*P Value <0.005

Availability of contraceptive Methods in hospital			
Enough	121(32)	177(46)	2.60(1.419-4.789)*
Not enough	37(10)	48(13)	1
Total	**158**	**225**	

P Value <0.005

DISCUSSION

In this study a total of 384 mothers were followed by Descriptive statistics and statistical model analysis presents the analysis and discussion of the data obtained from the study using structured questionnaire. Descriptive statistics and statistical model analysis were applied to describe the relation between dependent variables with explanatory variables and the effects of explanatory variables on the dependent variables are also presented. Strengthening family planning services is crucial to improving health, human rights, economic development and slowing population growth 1.

Effective family planning is identified as one of the top ten public health achievements of the United States during the 20th century.2 However, an estimated 225 million women who want to avoid pregnancy are not using safe and effective family planning methods for various reasons including lack of access to information or services and lack of support from their partners or communities. The majority of these women with an unmet need for contraceptives live in 69 of the poorest countries. This unmet need is fueled by both growing population and a shortage of family planning services.3,4 In the last two decades, the contraceptive prevalence among married, reproductive-aged women has increased worldwide.

Globally, contraceptive prevalence rose from 55% in 1990 to 63% in 2010.5 However, the unmet need for contraception has remained high in developing regions.6 In 2013, only about a quarter of married women were practicing family planning in Africa.7 Increasing access to family planning services is widely recognized as a priority public health issue at an international level. A number of global partnerships, including the International Conference on Population and Development in 1994,8 the Millennium Development Goal summit in 20009 and the London Summit on Family Planning in 2012, endorsed a global partnership known as Family Planning 2020 aimed to enable 120 million more women to use contraceptives by 2020 in 69 of the world's poorest countries.10

Improving the quality of care in family planning services is known to be key to improving the use of family planning services in developing countries, both by attracting new contraceptive users and by maintaining existing users (i.e. ensuring continued engagement with services).11-18 The need for family planning service in Ethiopia is evidenced by its population growth, morbidity and mortality statistics. Due to rapid population growth, systematic provision of

family planning service had begun in 1966, when the Family Guidance Association of Ethiopia (FGAE) was established as Non-Governmental, non-profitable organization by small group of concerned individuals (16).

In Ethiopia, there have been some efforts in family planning service to increase contraceptive prevalence rate. The Ethiopian population policy, which was adopted in 1993, has the objective of reducing the total fertility rate; as well as raising the contraceptive prevalence rate to a national coverage of 44% by the year 2015 (17). This effort was focused on expanding the service for previously uncovered areas by increasing the number of health institutions and other outlets. But still the Contraceptive Prevalence Rate is low (21.5%) (18). High fertility in Ethiopia is linked to both early marriage & low level of contraceptive use (19).

Family planning program alone in all circumstances cannot achieve the societal objectives of population stabilization. There must be a need to maintain the balance between availability and quality of service to improve family planning service utilization. Assessment of the 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). Recently, the idea of quality improvement has been used in managing health services, including those offered by Family planning Program (20).

Review of existing literatures strongly suggest that the quality of services provided are an important determinant of acceptance and continuation rates, and therefore a major contributor to increase in contraceptive prevalence rate (21).Studies regarding status of quality of F/P service in Ethiopia are not carried out sufficiently. However studies in Jimma (38), showed that, 69(10.9%) and 14(8.1%) of those who reported problems expressed dissatisfaction with waiting time and solution given by providers respectively. Method unavailability was the reason in most services delivery points for providing methods different from client choice. In this study again provider's special training and time of training have shown significant difference on quality of indicators. Several constraints in the service provision of family planning were also identified (38).

Another study in A.A (39) has shown that shortage of logistics and supplies, poor client record, inadequate supervision, poor counseling service, and long waiting time were major constraints to satisfy clients. These and other studies in developing countries showed that, the presence of low quality of family planning service contribute to lessened service utilization (21,38). Assessment

of the 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.

Despite the presence of family planning services, contraceptive prevalence rate is low in Ethiopia. Our finding of injectables(short acting method) as the predominant method of use (65%in2018) is in line with findings in many Sub-Saharan countries including Ethiopia,were Of the total respondents the majority, 149(38.8%) were using inject-able and followed by pills, 121(31,5%). According to this research's relating to the preference of contraceptive methods the majority, 163(42.4%) were preferring oral pills followed by injectables,115(29.9%). The remaining, 71(18.5%). 35(9.1%) were preferring IUCD and Norplant respectively.

CHAPTER FIVE: CONCLUSION AND RECOMMENDATION

5.1. Conclusion

The aim of the study was to assess the quality of family planning counseling provided in postnatal care at Armed Force Comprehensive Specialized Hospital Addis Ababa, Ethiopia. The quality of family planning counseling provided in postnatal care were unknown to fill the information, literature and methodology gaps for the academia, the government, ministry of health, hospitals, and the people.

The findings of the study indicate that among the respondents only 104(27.1%) were told about alternative contraceptive method but the majority, 280(72. %) of them were not counseled for alternative contraceptive methods. This implies that Adequate choice of contraceptives were not advised so that the mothers can choose the best contraceptive they wanted.The information provided to the clients was insufficient only 106(27.6%) of the subjects were told about the common side effects of contraceptive method, they were using but the majority, 278(72.4%) had not been informed about the side effects and what to do if it occurs this is the major problem that the women are facing and may lead them not to use the contraception again and the purpose of the presence of family planning service would be unnecessary if it does not met the vision. As such there is a need to scale up interventions geared towards addressing the quality of the family planning counseling.

The result of logistic regression analysis indicated that among the independent variables that are associated with adequacy of family planning counseling sessions estimated monthly income, number of Pregnancy and side effect encountered were statistically significant. The results of this analysis indicated that overall progress in modern contraceptive use has not been accompanied by a corresponding increase in the quality of family planning counseling. Improving the quality of contraception counseling for women across all demographics, including wealth quintiles and education, is a crucial strategy to support positive reproductive health outcomes with a rights-based focus.

5.2. Recommendation

Based on the findings of this study it is recommended

- Increase the number of methods used and provide sufficient information to clients.
- Increase community based reproductive health service sites; and give additional training for the health providers so that they can give quality family planning service in their area.
- It is essential to emphasize the need to do proper counseling for all methods including short-acting methods especially for those working the private sector and some of the regions which have lower prevalence of good counseling.
- Policies should continue to highlight the importance of reproductive health and family planning needs of adolescent and youth since the county is mostly a young population.
- Efforts to improve the quality should focus on improving the working environment of providers in terms of infrastructure addressing human recourse shortage remanding and supervising deficiencies and skill training
- Policies should encourage individuals that the providing counseling across all sectors to receiving comprehensive training of only with the technical skills needed for effective counseling the provision of teaching aid materials and appropriate spaces that foster privacy for counseling activities may support the provision of high quality counseling across settings and demographics.
- Contraception providing and programs can also take the initiative in adopting accepted guidelines such as the WHO's quality of care in contraception information and services based on human right standards check list to support practices conducive to high quality service.

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Appendix

Appendix 1 information sheet

Addis Ababa University
College of Development Studies
Center for Population Studies

Questionnaire

Dear respondents,

I am here on behalf of **Yemane G/Meskel** from Addis Ababa University. We are conducting a survey on *quality of family planning counseling service given at post-natal clinic at Armed Force Comprehensive Specialized Hospital in Addis Ababa Ethiopia*. The study is being conducted as a partial fulfillment of the requirements for a degree of Master of Science in Population Studies at Addis Ababa University. The information obtained through this questionnaire will only be used for the research purpose. The quality of this study highly depends on the information provided by you. Whatever information you provide me will be kept strictly confidential. You will not be asked to write your name or any other identifiers. You can skip questions that you don't want to answer or withdraw from the study at any time of the interview. Thus, I kindly request your participation and thank you in advance for your kind cooperation!!

Are you willing to participate?

☐ Yes ☐ No (*If No Please Skip to the next respondent*)

Part I: Socio-demographic and economic characteristics respondents.

No.	Item	Categories and coding		Skip
101	Age (in completed years)		1. 15-19	
			2. 20-24	
			3. 25-29	
			4. 30-34	
			5. 35-39	
			6. 40-44	
			7. 45-49	
102	Marital status		1. Single (Never married)	
			2. Married	
			3. Divorced	
			4. Widowed	
103	Educational status		1. No education	
			2. Primary	
			3. Secondary	
			4. Above secondary	

No.	Item	Categories and coding		Skip
104	Religion		1. Orthodox	
			2. Muslim	
			3. Catholic	
			4. Traditional	
			5. Others	
105	Occupation		1. Housewife	
			2. Government employee	
			3. Self employed	
			4. Daily laborer	
			5. Unemployed	
			6. Others	
106	Average estimated monthly income	_____		
107	Place of residence		1. Urban	
			2. Rural	
108	Number of pregnancy so far	_____		
109	Total number of livebirths	_____		
110	Number of children alive now	_____		

Part II: Contraceptive mothed currently being used and family planning counseling

No.	Item	Categories and coding		Skip
201	Type of modern contraceptive method currently using		1. Pills	
			2. Condom	
			3. Injectables	
			4. IUD	
			5. Implant	
			6. EC	
			7. Female sterilization	
			8. Male sterilization	
			9. Other modern	
202	During family planning counseling, were you informed about alternative contraceptive methods?		1. Yes	
			2. No	
203	During family planning counseling, were you informed about the side effects of each method?		1. Yes	
			2. No	
204	During family planning counseling, were you told what to do if side effects were to occur?		1. Yes	
			2. No	
205	From the contraceptive you are using have you encountered the side effect of the contraceptive		1.yes 2.no	
206	Is there an availability of different contraceptive methods in the hospital?		1.enough 2.not enough 3.not available	
207	Which contraceptive method did you		1.oral pill	

No.	Item	Categories and coding		Skip
	decided to take?		2.injectable 3.IUCD 4.Norplant	
208	From where do you get information about family planning?		1.friend 2.health worker 3.mass media 4.others	
209	Have you get a new idea about reproductive health from the counseller?		1.yes 2.no	
210	Have you get enough knowledge about the acceptance of adolescent family planning from the community by the counceller?		1.enough 2.not enough	
211	Where do you obtain (current contraceptive method)the last time?		1.public 2.private	

Part III: Provider competence and institution related questions

No.	Item	Categories and coding		Skip
301	What is the providers category?		1.mid wife 2.nurse 3.Doctor 4 .Gynacologist	1
				2
302	Was the providers activity supervised?		1. Yes b.no	3
303	The interpersonal skill & technical competence of the provider is?		1. V.good 2. good 3 .fair 4 excellent	4
304	Was the provider using infection control guide line appropriately?		1.yes 2.no	5
305	Was the hospital environment attractive&clean ?		1.yes 2.no	6

አዲስ አበባ ዩኒቨርሲት
የልማት ጥናቶች ኮሌጅ
የህዝብ ብዛት ጥናት ማዕከል

መጠይቅ

ውድ ምላሽ ሰጪዎች

ከአዲስ አበባ ዩኒቨርሲቲ የማነ ገ / መስቀል ወከዬ እዚህ ነኝ ። በአዲስ አበባ ኢትዮጵያ በጦር ኃይሎች ልዩ ልዩ ስፔሻላይዝድ ሆስፒታል በድህረ-ወሊድ ክሊኒክ በተሰጠው የቤተሰብ ምጣኔ ሀብት አገልግሎት አሰጣጥ ጥራት ላይ የዳሰሳ ጥናት እያደረግን ነው ። ጥናቱ በአዲስ አበባ ዩኒቨርስቲ በሕዝብ ብዛት ጥናት የሳይንስ ማስተር ዲግሪ የሚያስፈልጉትን ከፊል ፍፃሜ በማካሄድ ላይ ይገኛል ። በዚህ መጠይቅ በኩል የተገኘው መረጃ ለምርምር ዓላማ ብቻ የሚውል ነው ። የዚህ ጥናት ጥራት በእጉ በሚሰጡት መረጃ ላይ በእጅጉ የተመካ ነው ። ለእኔ የሚሰጡኝ ማንኛውም መረጃ በጥብቅ በሚስጥር ይቀመጣል ። ስምዎን ወይም ሌላ ማንነቶችን እንዲጽፉ አይጠየቁም ። በቃለ መጠይቁ በማንኛውም ጊዜ መልስ ለመስጠት ወይም ከጥናቱ ለመውጣት የማይፈልጓቸውን ጥያቄዎች መዝለል ይችላሉ ። ስለሆነም ተሳትፎዎን በትህትና እጠይቃለሁ እና ስለ ደግ ትብብርዎ አስቀድሜ አመሰግናለሁ !!ለመሳተፍ ፈቃደኛ ነዎት?

☐ አዎ ☐ የለም (የለም *ከሆነ እባክዎን ወደ ቀጣዩ ተጠሪ ይዝለሉ*)

ክፍል I : የስነ ህዝብ እና ኢኮኖሚያዊ ባህሪ ምላሽ ሰጭዎች ።

አይ.	**ንጥል**	**ምድቦች እና ኮድ ማውጣት**		**ዝለል**
101	ዕድሜ (በተጠናቀቁ ዓመታት ውስጥ)		1. 15-19 2. 20-24 3. 25-29 4. 30-34 5. 35-39 6. 40-44 7. 45-49	
102	የጋብቻ ሁኔታ		1. በጭራሽ አላገባም 2. ያገባ 3. የተፋታች 4. መበለት	
103	የትምህርት ሁኔታ		1. ትምህርት የለም 2. የመጀመሪያ ደረጃ 3. ሁለተኛ ደረጃ 4. ከሁለተኛ ደረጃ በላይ	
104	ሃይማኖት		1. ኦርቶዶክስ 2. ሙስሊም 3. ካቶሊክ 4. ባህላዊ 5. ሌሎች	
105	ሥራ		1. የቤት እመቤት 2. የመንግስት ሰራተኛ 3. በግል ተዳዳሪ 4. ዕለታዊ ሠራተኛ	

አይ.	ንጥል	ምድቦች እና ኮድ ማውጣት		ዝለል
			5. ሥራ አጥነት 6. ሌሎች	
106	አማካይ ወርሃዊ ገቢ		_____	
107	የመኖሪያ ቦታ		1. የከተማ 2. ገጠር	
108	እስካሁን ድረስ የእርግዝና ብዛት		_____	
109	ጠቅላላ የወሊድ መወለዶች		_____	
110	አሁን በሕይወት ያሉ የልጆች ብዛት		_____	

ክፍል II : - የወሊድ መከላከያ ዘዴ በአሁኑ ጊዜ ጥቅም ላይ እየዋለ እና የቤተሰብ ምጣኔ ምክር

አይ.	ንጥል	ምድቦች እና ኮድ ማውጣት		ዝለል
201	በአሁኑ ጊዜ እየተጠቀመ ያለው ዘመናዊ የወሊድ መከላከያ ዘዴ ዓይነት		1. ክኒኖች 2. ኮንዶም 3. መርፌዎች 4. አይ.ዩ.ዲ. 5. ተከላ 6. ኢ.ሲ. 7. ሴት ማምከን 8. የወንዶች ማምከን 9. ሌላ ዘመናዊ	
202	በቤተሰብ ዕቅድ ዝግጅት ምክር ወቅት ስለ አማራጭ የእርግዝና መከላከያ ዘዴዎች መረጃ ይሰጥዎታል?		1. አዎ 2. አይ	
203	በቤተሰብ ዕቅድ ዝግጅት ወቅት ስለ እያንዳንዱ ዘዴ የጎንዮሽ ጉዳቶች መረጃ ተሰጥቶዎታል?		1. አዎ 2. አይ	
204	በቤተሰብ ዕቅድ ዝግጅት ወቅት የጎንዮሽ ጉዳቶች የሚከሰቱ ከሆነ ምን ማድረግ እንዳለብዎ ተነግሮዎታል?		1. አዎ 2. አይ	
205	ከሚጠቀሙት የወሊድ መከላከያ የወሊድ መከላከያ የጎንዮሽ ጉዳት አጋጥሞዎታል?		1. አዎ 2. የለም	
206	በሆስፒታሉ ውስጥ የተለያዩ የእርግዝና መከላከያ ዘዴዎች አሉ?		1. በቂ 2. በቂ አይደለም 3. አይገኝም	
207	የትኛውን የእርግዝና መከላከያ ዘዴ ለመውሰድ ሞክረዋል ?		1. መደበኛ ክኒን 2. በመርፌ የሚረጭ 3. አይ.ሲ.አይ.ዩ.	
208	ስለቤተሰብ ዕቅድ መረጃ ከየት አገኙ?		1. ጓደኛ 2. የጤና ሰራተኛ 3. ማስታወቂያ 4. እናቶች	

አይ.	ንጥል	ምድቦች እና ኮድ ማውጣት		ዝለል
209	ስለ ስነተዋልዶ ጤና ከአማካሪው አዲስ ሀሳብ አግኝተዋል ?		1. አዎ 2. የለም	
210	በጉርምስና ዕድሜ በቤተሰብ ዕቅድ አገልግሎት ከማህበረሰቡ ቅቡልነት ጋር በተያያዘ ከአማካሪው በቂ እውቀት እና ምክር አግኝተዋል?		1. በቂ 2. በቂ አይደለም	
211	ለመጨረሻ ጊዜ የተጠቀምሽው የወሊድ መከላከያ ዘዴ (የአሁኑ)የት ነው ያገኙት ?		1. ሕዝብ 2. ግል	

ክፍል III- ከአቅራቢዎች ብቃት እና ከተቋማት ጋር የተያያዙ ጥያቄዎች

አይ.	ንጥል	ምድቦች እና ኮድ ማውጣት		ዝለል
301	የምክር አገልግሎት የሰጠዎት ሙያተኛ ምድብ ምንድነው?		1. አዋላጅ ነርስ 2. ነርስ 3. ዶክተር /ኃኪም 4. የማህፀን ኃኪም	
302	የሙያተኛው እንቅስቃሴ ቁጥጥር ተደርጎ ነበር?		1. አዎ 2. አይ	
303	የምክር አገልግሎት ሰጪው አቀባበል እና ምክር አሰጣጥ እንዴት ነበር?		1. በ. ጥሩ 2. ጥሩ 3. ፍትሃዊ 4. መጥፎ	
304	አቅራቢው የኢንፌክሽን መቆጣጠሪያ መመሪያ መስመርን በአግባቡ እየተጠቀመ ነበር? (ለምሳሌ፡- ጉአንት፣ጭምብል)		1. አው 2. የለም	
305	የ ሆስፒታል አካባቢ ማራኪ እና ንጹህ ነበር?		1. አዎ 2. የለም	