



ADDIS ABABA UNIVERSITY
COLLEGE OF DEVELOPMENTAL STUDIES
CENTER FOR POPULATION STUDIES- REPRODUCTIVE HEALTH

**CLIENT SATISFACTION AND ITS DETERMINANTS AMONG FAMILY
PLANNING SERVICE UTILIZER IN ARADA SUB-CITY, ADDIS ABABA,
ETHIOPIA**

By:

AKNANAW BEZABIH

October, 2023



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**A THESIS SUBMITTED TO THE SCHOOL OF GRADUATES STUDIES OF THE ADDIS
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SCHOOL OF GRADUATES STUDIES
COLLEGE OF DEVELOPMENTAL STUDIES
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APPROVAL SHEET

This is to certify that the thesis prepared by Aknanaw Bezabih Desalegn, entitled “**Client Satisfaction and its Determinants among Family Planning Service Utilizers in Arada Sub City, Addis Ababa, Ethiopia,**” and submitted in partial fulfillment of the requirements for the degree of Masters of Science in population studies (reproductive health), is in compliance with the regulations of the university and meets the accepted standards with respect to originality and quality.

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Deceleration

I, the undersigned hereby certifies that the thesis, "Client Satisfaction and its Determinants among Family Planning Service Utilizers in Arada Sub City, Addis Ababa, Ethiopia," is an original work writing that has never been presented before in order to be considered for any academic a degree or diploma. I further certify that no chapter of this thesis, in whole or in part, contains any of my own or others' previous work. This thesis includes proper acknowledgments for all sources utilized. Important ethical considerations in this research include the participant's right to confidentiality and their ability to withdraw from the study without repercussions.

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Abbreviations

ANC	Antenatal Care
CPR	Contraceptive prevalence Rate
CSA	Central Statistical Agency
EDHS	Ethiopian Demographic and Health Survey
EPHI	Ethiopian Public Health Institute
FGAE	Family Guidance Association of Ethiopia
FMOH	Federal Minister of Health
FPS	Family Planning Services
HEP	Health Extension Program
HEW	Health Extension Worker
HSDP	Health Sector Development Plan
IUD	Intrauterine Device
IPPF	International Planned Parenthood Federation
LAM	Lactational Amenorrhea Method
LMIC	Lower and Middle Income Country
OCP	Oral Contraceptive Pills
PNC	Postnatal Care
PHCU	Primary Health Care Unit
SDG	Sustainable Development Goal
SPO	Structure process and outcome
SRH	Sexual and Reproductive Health
STI	Sexual Transmitted Infection
SSA	Sub-Saharan African
UN	United Nation
WHO	World Health Organization

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Abstract

Background of the study: Family planning is a conscious decision by individuals or couples to choose for themselves when to start having children, how many children to have, how to space them or when to stop having children by using (modern) contraception and natural methods. Good quality care in family planning services helps individuals and couples meet their reproductive health needs safely and effectively. **Objective:** To assess the quality of family planning services and its determinants in public health centers of Arada sub-city Addis Ababa, Ethiopia. **Method:** Facility-based cross-sectional study was conducted from 15th March to May 25th 2023 on family planning clients in Arada sub-city Addis Ababa, Ethiopia. Systematic simple random sampling technique was used to get a total of 301 clients in ten health centers as study population. Data was collected using structured questionnaires and was analyzed using SPSS version 24. Bi-variable and multivariable analysis was used to identify the determinant factors associated with client satisfaction among family planning service utilizers in Arada sub-city. **Result:** The study revealed the quality measure components as 98% for regular availability of methods, 78.5% for information provision with full explanation of methods, 78% for interpersonal relationship with communication clarification, 97.7% clients' agreement on provider competence. The overall composite satisfaction score was 75.2%. The multivariable analysis results revealed that the service quality satisfaction for those clients' marital status, educational status, source of information, and the availability of sufficient methods were important factors and significance associations. Regarding marital status, the results showed that being married (78.1%), divorced (62.5%), or widowed (58.3%) was significantly associated with a higher perception of receiving quality family planning service compared to being single. Married had a crude odds ratio (COR) of 4.854, divorced had a COR of 8.100, and widowed had the highest COR of 9.643. The marital status (married, divorced, or widowed) associations were statistically significant with p-values of 0.038, 0.007, and 0.007, respectively. Overall, the interview results indicate that most family planning service providers are skilled and educated in providing high-quality services, even though there is room for improvement.

Conclusion: This study revealed that about three-fourth (75.2%) of the clients were satisfied with the service they received and the overall quality measure is good in the provisions of FPS. However, approximately one third of the clients (23.5%) express the need for targeted improvements in two specific areas: the availability of supplies and the presence of trained personnel. By addressing these areas, it is believed that client satisfaction regarding the quality of family planning services can be enhanced, leading to better alignment with client needs. Policymakers and healthcare providers should consider these factors when designing targeted interventions and improving service delivery to ensure equitable access to family planning services, and to explore additional factors and their impact on the quality of family planning services to ensure comprehensive and effective reproductive healthcare services.

Keywords: family planning, client satisfaction, quality of FP service, health center

CHAPTER ONE

INTRODUCTION

1.1. Background

Family planning is a conscious decision by individuals or couples to choose for themselves when to start having children, how many children to have, how to space them or when to stop having children by using (modern) contraception and natural methods (United Nations New York, 2020).

Access to and use of family planning is critical for reaching the recently announced Sustainable Development Goals, either directly or indirectly (SDGs). Through its role in preventing unwanted pregnancy and lowering the overall fertility rate, it can help to reduce chronic poverty and hunger, increase access to quality education, Address Climate Change Challenges, ensure sustainable consumption, improve gender equality, improve maternal health, and reduce childhood mortality (Starbird et al., 2016).

In 2017, 63 percent of married or in-union women of reproductive age used some type of contraception, whether modern or traditional (Kantorová et al., 2020). In Africa, 36 percent of reproductive-age women use some type of contraception, but 22 percent have an unmet need for modern contraception, with Sub-Saharan Africa accounting for the majority of this (Tibaijuka et al., 2017). Even according to the 2016 Ethiopia demographic health survey (EDHS), 36 percent of currently married women and 58 percent of unmarried sexually active women use some type of contraception. The World Health Organization (WHO) cites the following reasons: limited choice of family planning methods, limited access to contraception, poverty, fear or experience of side effects, cultural or religious opposition, poor quality of available family planning services (Mccleary-Sills et al., 2012).

Factors influencing contraceptive use in many Sub-Saharan African (SSA) countries, including Ethiopia, include lack of physical access, desire for more children, age, side effects of contraception, transportation problems, lack of access to mass media, and husband and community attitudes. Physical barriers to health services include lack of physical access, including transportation and/or proximity to clinics; lack of ramps, adapted examination tables, and the like; and laziness (e.g. lack of materials in Braille, large print, simple language, and pictures; lack of sign language interpreter) (Mosher et al., 2017; Sedgh et al., 2016; Wulifan et al., 2016).

1.2. Statement of the problem

In Ethiopia, Quality of family planning encompasses a wide range of problems including technical competence, choice of methods, information given to clients, interpersonal relationships and appropriate constellation of services. The need for family planning services in Ethiopia is evidenced by its population growth, morbidity and mortality statistics, due to rapid population growth (BA, 2017). The unmet need for quality of family planning services in Ethiopia is believed to be high while the already available services do not appear to be optimally used by potential clients (Tasew, 2017). High fertility rate is a major issue in many developing countries due to its long term effect on social and economic development. Deeply rooted traditional beliefs and values coupled with low level of Quality of FP use are among the factors that lead to high fertility rate (Digga D, Ying G, 2019). Ethiopia has one of the worst rates of maternal mortality in Africa. 412 maternal deaths per 100,000 live births were the maternal mortality rate due to poor use of FP methods (CSA and ICF, 2016).

At present, despite Ethiopia being part of several global and local commitments towards improving access to FP, the CPR is still low, although a significant improvement has been observed in the past 16 years (8% in 2000, 14.7% in 2005, 28.6% in 2011, and 35% in 2016) (CSA and ICF, 2016). According to the recent Ethiopian Demographic and Health Survey (EDHS) 2016 report, more than one third (35%) of Ethiopian women who commence contraception discontinue use within 12 months of initiation and the discontinuation rates vary by the method of contraception. The discontinuation rates were particularly high for oral contraceptive pills (70%), injectable (38%) and Intrauterine Device (IUD) (13%) (CSA and ICF, 2016). Moreover, another study based on a secondary analysis of the EDHS 2011 data showed a contraceptive discontinuation as high as 56% (CSA and ICF, 2016). According to this study, quality of care related issues such as lack of or fear of compromising confidentiality for clients in FP services, negative personal experience of contraceptive methods, and rumors about other women's negative experiences in using contraceptive methods were some of the reasons for contraceptive discontinuation. The reasons for such high discontinuation rates are not clearly understood. However, several studies from developing countries have found that poor quality of care in FP services is a prime reason for high rates of discontinuation, reduced utilization of FP services, non-compliance, and high unintended pregnancies (Tessema et al., 2017).

Three different studies conducted in different parts of Ethiopia found that Implanon discontinuation was associated with lack of counseling prior to the method's insertion, lack of follow-up, and being not satisfied by the services provided. Similarly, several studies from LMIC have linked poor quality of FP services to high rates of discontinuation, reduced utilization, non-compliance, and high unintended fertility (Tessema, 2018). As far as the literature search is concerned, there is a low performance of quality of FP in the study area of Arada sub-city, Addis Ababa. In addition to the limited number of evidence, quality of health services needs to be assessed periodically to better strengthen the quality of the services and promote service uptake. As a result, this research will fill an information gap about the client satisfaction on the quality of FP services and give local evidence for context-specific decision-making., also intend to determine the factors affecting client's satisfaction, which will help to identify target area of improving FP services.

1.3. Research Questions

- What does the quality of family planning services in terms of client satisfactions of public health centers in Arada sub-city, Addis Ababa look like?
- What are the determinants of quality of family planning service in the public health centers Arada sub-city, Addis Ababa?

1.4. Research Objectives

➤ General Objective

- To assess the client satisfaction of family planning services of public health centers and its determinants in Arad sub-city, Addis Ababa, Ethiopia, 2023

➤ Specific Objectives

- To assess the quality of family planning services in public health centers in Arada sub-city, Addis Ababa
- To identify determinant factors of family planning services in public health centers of Arada, sub-city Addis Ababa.

1.5. Significance of the Study

This research will fill a knowledge gap and understanding the state of family planning service quality is critical and a fundamental input for reproductive health and family planning program monitoring, assessment, and implementation. The study analyzes the quality of family planning services and determinant factors in the public health institutions of Arada sub-city. It is hoped to aid health-care providers, policymakers, and other groups in improving Family planning services in public health facilities.

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1.6. Scope and Limitations of the Study

Scope of the Research:

The research focuses on the provisions of family planning services and the factors determining their quality specifically at public health centers in Arada Sub-city, Addis Ababa. The aim is to understand the determinants of quality in terms of perceptions of satisfaction in family planning services and their impact on the health and well-being of families.

Sampling and Methodology Scope: The research sample is limited to public health centers in Arada Sub-city, excluding private-wing health service providers. Data collection took place during the period from March 15 to May 25, 2023, specifically targeting individuals seeking family planning services at the selected public health centers during the study period. Please note that the limitations mentioned above may impact the generalizability of the findings beyond the specific sample and geographical scope. Therefore, caution should be exercised when applying the research findings to other public health centers or regions in Addis Ababa.

Geographical Scope: The geographical coverage of the research is focused on Arada Sub-city, Addis Ababa, Ethiopia. The findings and conclusions are specific to this particular sub-city and may not be generalizable to other areas or public health centers in Addis Ababa.

Thematic Scope: The thesis primarily examines the provision of family planning services and its determinant factors using descriptive and multivariate studies. It does not encompass other aspects of healthcare providers or services offered by public health centers. The findings and conclusions are limited to the specific thematic scope of family planning services within the context of the study.

Limitations of the Study:

The study acknowledges certain limitations due to time and budget constraints. The sample size may not be large enough to fully represent all public health centers in Addis Ababa, which could affect the generalizability of the findings. Additionally, the research initially intended to include data from all public health centers in Addis Ababa but had to limit the focus to the public health centers in Arada Sub-city due to the constraints mentioned. Despite these limitations, the research provides valuable insights into the determinants of quality in family planning services within the specific context of Arada Sub-city, Addis Ababa. It serves as a foundation for further research and understanding in this area.

Time and budget Limitation: Furthermore, the time and budget limitations may have affected the comprehensiveness of the data collected. The researchers made efforts to collect data from a wide range of sources, but the constraints may have restricted the depth and breadth of the study. Considering these limitations when interpreting the results and drawing conclusions is important. Despite these limitations, the research provides valuable insights into the determinants of quality in family planning services in the context of Arada Sub-city. The findings can inform policymakers, healthcare professionals, and relevant stakeholders in identifying areas for improvement and implementing strategies to enhance the quality of family planning services. It is recommended that future research endeavors in this area consider expanding the sample size and including a broader geographical scope to enhance the generalizability of the findings. Additionally, allocating sufficient time and resources for data collection would allow for a more comprehensive analysis of the determinants of quality in family planning services. Overall, this study contributes to the existing body of knowledge regarding family planning services in Arada Sub-city, Addis Ababa. While the findings may have limitations, they provide a foundation for further research and serve as a starting point for future efforts to improve the quality of family planning services in the region.

CHAPTER TWO

LITERATURE REVIEW

2.1. Theoretical Literature

Quality of care in family planning encompasses a wide range of issues including technical competence, choice of methods, the information given to clients, interpersonal relationships, and an appropriate consultation of services. Several studies have shown that quality of care greatly influences the uptake and continuation of using the of family planning services (Birhanu et al., 2019). Quality has been a difficult concept to define and measure. Its difficulty is attributed to its subjective nature and intangible characteristics (Mosadeghrad, 2012). It is particularly more difficult in the healthcare sector due to the distinct nature of the healthcare industry in terms of its intangibility, heterogeneity, and the existence of many participants with different interests in the healthcare delivery(Tessema, 2018). In a generic approach, quality is defined as excellence, expectations or goals which have been met, ‘zero defects’ or fitness for purpose. However, due to that generic definitions are not easy to operationalize and lack of sensitivity and specificity for generalization, a disaggregated approach that recognizes quality as a complex and multidimensional concept was in placed by different scholars (Tessema, 2018).

Any service must offer quality in order to draw in and keep clients. Historically, the term "quality" has been used to describe clinical practices that provide clients with technically sound, efficient, and safe care. The degree to which health services for individuals and populations increase the of desired health outcomes and are compatible with current professional knowledge is referred to as "quality of health care" by the United States Institute of Medicine(Tafese et al., 2013).

Quality of family care includes, but is not limited to, availability of the services and/or supplies, characteristics of health care provider, adherence to the standard of care and client’s expectation and perception. For clients, quality is related to availability, waiting time, privacy, information and services received. On the other hand, for health service provider’s quality is linked to outcome of services, safety, decline in morbidity and mortality and increase in services coverage (Tafese et al., 2013). Family planning (FP) is defined as the capability of individuals and couples to anticipate and attain their desired number of children, spacing and timing of their births. FP service saves the lives

of women and children and improves the quality of life for all. It is one of the best investments that can help to ensure the health and well-being of women, children, and communities (Abay et al., 2022).

Quality of Care plays a significant part within the sexual and reproductive health (SRH) paradigm, including family planning (FP) services, as it is a crucial method for ensuring human rights in the provision of health care services. The term "quality of care" encompasses a wide range of definitions and elements. In general, it can be described as the interaction between the client and the expected level of care they will receive within the context of health care services. The concept of quality of care is distinct from the concept of access, which primarily concentrates on all the factors that guarantee the accessibility of health care services. (Kriel et al., 2021). Quality in FP services encompasses facility-level structural components, such as the availability of services and contraception methods, and components related to the client such as privacy during consultations, waiting times, and information received during FP counseling (Hrusa et al., 2020). According to the 2016 Ethiopian Demographic and Health Survey, there were 4.6 children born to per woman overall, and 36% of women used contraceptives. In contrast, the national and Oromia rates of unmet family planning need were 22% and 29%, respectively. The surveys also show that the maternal mortality ratio, which was 412 deaths per 100,000 live births, has significantly decreased. (CSA and ICF, 2016).

Barriers to increased access to family planning and contraception include and are not limited to restrictive religious and cultural norms, levels of education, access to healthcare, and poor quality of FP services (Hrusa et al., 2020). The need to keep raising the standard of healthcare is widely acknowledged in both the national and international populations. Since the beginning of the nineteenth century, improvements have been made to mothers' and kids' health all across the world. Reproductive health (RH) services were expanded to include family planning (FP) in 1994 by the International Conference on Population and Development (ICPD). In many developing nations, including Ethiopia, family planning programs concentrate their efforts on reaching specific demographic objectives including birth-rate decreases and slower population growth through higher usage and coverage of family planning services. It is unquestionably impacted by the standard of family planning services that are offered to the general public. Family planning is also considered as one of the strategies for the reduction of maternal and child mortality rates which largely depend on the quality of the services provided to the population (Tafese et al., 2013). In Ethiopia, modern FP services are available through community and facility-based approaches. Modern FP methods

include the oral contraceptive pill, IUD, injectable, implants, male and female condoms, Lactational Amenorrhea Method (LAM), emergency contraception, female and male sterilization, and standard day method(CSA and ICF, 2016).

Quality family planning is a key component in enhancing mother and child health. Due to its critical role in preventing unwanted pregnancy and consequences like abortions and teenage pregnancy, FP plays a significant role in lowering maternal mortality. Additionally, when a sufficient gap between pregnancies is obtained with the use of Quality FP techniques, negative neonatal outcomes like preterm and low birth weight can be avoided, which contributes to a decrease in child mortality.(Tessema, 2018). Evidence suggests that efficient FP services can lower baby, maternal, and child mortality by 10%, 40%, and 21%, respectively. In addition, quality FP is crucial for human growth, women's emancipation, and poverty alleviation. Women who practice FP have fewer children on average and subsequently have better options for education and jobs, which increases their household income levels. (Tessema, 2018).

More recently, the Sustainable Development Goals (SDGs), which are a continuation of the MDGs, put FP as one of the key priority towards achieving its Goal 3 on health and Goal 5 on gender equality and women empowerment. FP services are important in achieving these two SDGs, and investing on FP will also help accelerate the achievement of almost every goal in the 17 SDGs (Starbird et al., 2016). Even though it was well behind the MDG target of 267 per 100,000 live births in 2015, the MMR decreased from 871 fatalities per 100,000 live births in 2000 to 412 deaths per 100,000 live births in 2016. The rise in female contraceptive use has been partially blamed for this decline in fertility and maternal mortality. Political support, donor funding, non-governmental organizations, public-private partnerships, the government's Health Extension Program (HEP), which helps to provide access to FP services in underserved areas of the country, are all factors in Ethiopia's increase in FP use over the past 20 years(Tessema, 2018).

2.2. Empirical Literature

Empirical studies in Sokoto, Northern Nigeria have shown facility-related factors such as managing authority (public or privately owned), availability of a variety of methods and waiting time (Kaoje et al., 2015) 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)(Tafese et al., 2013) and 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(Digga D, Ying

G, 2019). To date only a few small-scale studies have been conducted to assess quality of care in FP services in Ethiopia. These studies were limited to public health facilities or failed in identifying the factors determining quality of care in FP services. These studies that identified factors associated with quality of care in FP services were pointed to quality of care was associated with client's age, educational status, providers' experiences, client's waiting time, clients' perception on adequacy of information during consultation, ease of getting the health facility (Tessema et al., 2017).

The total level of satisfaction was determined to be around 78 percent in a facility-based cross-sectional research done at the Metu Karl Referral Hospital in South West Ethiopia. In the multivariable logistic regression analysis, education level (AOR = 4.31, 95% CI (1.78, 10.46), clinic convenience (AOR = 8.76, 95% CI (4.10, 18.71), maintaining privacy during the examination and procedure (AOR = 19.24, 95% CI (8.87, 41.71), explaining the procedure (AOR = 5.84, 95% CI (2.91, 11.73), and being informed of potential side effects (AOR = 5.29, 95% (Digga D, Ying G, 2019).

Another study done in Africa in 2016 called Factors Determining Quality of Care in Family Planning Services in Africa indicated that the health facilities in the three components of quality measurement. From 11 studies, 8 (all quantitative) and 3 (all qualitative) met the requirements for the review. According to the analysis, client, provider, facility, and facility characteristics, as well as structural and procedural aspects of the facilities, all had an impact on the quality of care. The most often mentioned process elements included client wait times, practitioner skill, availability of/prescription for injectable treatments, and protecting confidentiality and privacy. The most frequently noted structural factor was the caliber of stock inventory (Tessema et al., 2016). The caliber of care was another benefit for hospitals that were privately run. The qualitative synthesis showed other factors, such as access-related ones like "pre-requisites to be satisfied by the clients and cost of services, provider workload, and providers' behavior." (Tessema et al., 2016).

A study conducted in Ethiopia found that the proportion of female contraception users that reported receiving information on all three questions did not significantly change over the period 2014 to 2018. Overall quality of counseling on family planning was low, with only 30% of women reporting receiving sufficient information during counseling. The perceived of good quality counseling was the least among those who had no formal schooling when compared to those who had higher educational attainment (OR = 0.70, 95% CI: 0.50, 0.97). Women from the wealthiest quintile were 1.72 times more perceived (95% CI: 1.10, 2.69) to receive good quality counseling when compared to women in the lower wealth quintile. Women from rural areas were 1.51 times more perceived to

have received good counseling when compared to those in urban areas (95% CI: 1.04, 2.18). Amhara residents were less perceived to receive good counseling when compared to the SNNPR (OR: 0.51, 95% CI: 0.32, 0.81). Women who acquired their method from the private sector had worse counseling (OR: 0.31, 95% CI: 0.23, 0.41) when compared to the public sector. Those using short-acting methods were more at risk of receiving lesser quality counseling when compared to users of long-acting methods (OR: 0.58, 95% CI: 0.46, 0.72)(Hrusa et al., 2020).

Other studies in Ethiopia the results of unadjusted and adjusted regression analysis comparing structural quality of FP services between public and private PHCU facilities in Ethiopia. In terms of the availability of FP methods private facilities were less likely to have injectable contraceptive methods (AOR 0.20; (0.06, 0.68), IUD (AOR=0.22, 95%CI: 0.13, 0.38), and implants (AOR=0.06; 95%CI: 0.03, 0.12), but were more perceived than public facilities to have emergency contraceptive methods (AOR=3.81; 95% CI: 2.37, 6.10). When compared with public facilities, private facilities were less likely to have health providers available 24 hours in the facility (AOR=0.35; 95% CI: 0.18, 0.69), providers who received FP training in the past 24 months (AOR=0.23; 95% CI: 0.14, 0.41), a quality assurance system in terms of reviewing the health facilities' users data (AOR=0.07; 95% CI: 0.02, 0.21), FP guidelines/protocols (AOR=0.33, 95% CI: 0.19, 0.54), and client chart/record to document the client's clinical data (AOR=0.22; 95% CI: 0.13, 0.36)(Tessema, 2018).

Another descriptive cross-sectional study conducted in Addis Ababa showed that women were 6.6 times more likely to have high satisfaction when their provider asked about their partner's attitude toward contraceptive methods (adjusted OR [AOR], 6.6; 95%, CI, 2.5–8.0; P<0.001). Women whose provider asked about their concerns and worries regarding family planning contraceptive methods were five times more to express a high level of satisfaction (AOR, 5.1; 95% CI, 2.3–11; P<0.001). Women were 4.7 times more to have a high level of satisfaction when the healthcare provider acknowledged their concerns about family planning (AOR, 4.7; 95% CI, 2.1–10.4; P<0.001). If the healthcare provider did not recommend a specific contraception method for the woman, the woman was 17.7 times more likely to have a high level of satisfaction when the reason for not recommending a specific method was discussed by the healthcare provider (AOR, 17.7; 95% CI, 7.0–10.4; P<0.001)(Teshome et al., 2017).

Study conducted in Jimma clients who were unable to read and write were 64% less likely to be satisfied than those who completed primary and secondary or preparatory schooling (AOR=0.363: CI: 0.160, 0.822), and clients who were waiting for < 30 minutes at waiting area were 2.7 times more likely to be satisfied than those who waited for ≥ 30 minutes (AOR=2.769: CI: 1.300, 5.898). Clients

who received information on what to do in cases of any problem were 2.8 times more likely to be satisfied than those who Did not receive the information (AOR=2.846:CI:1.371,5.909) (Birhanu et al., 2019).

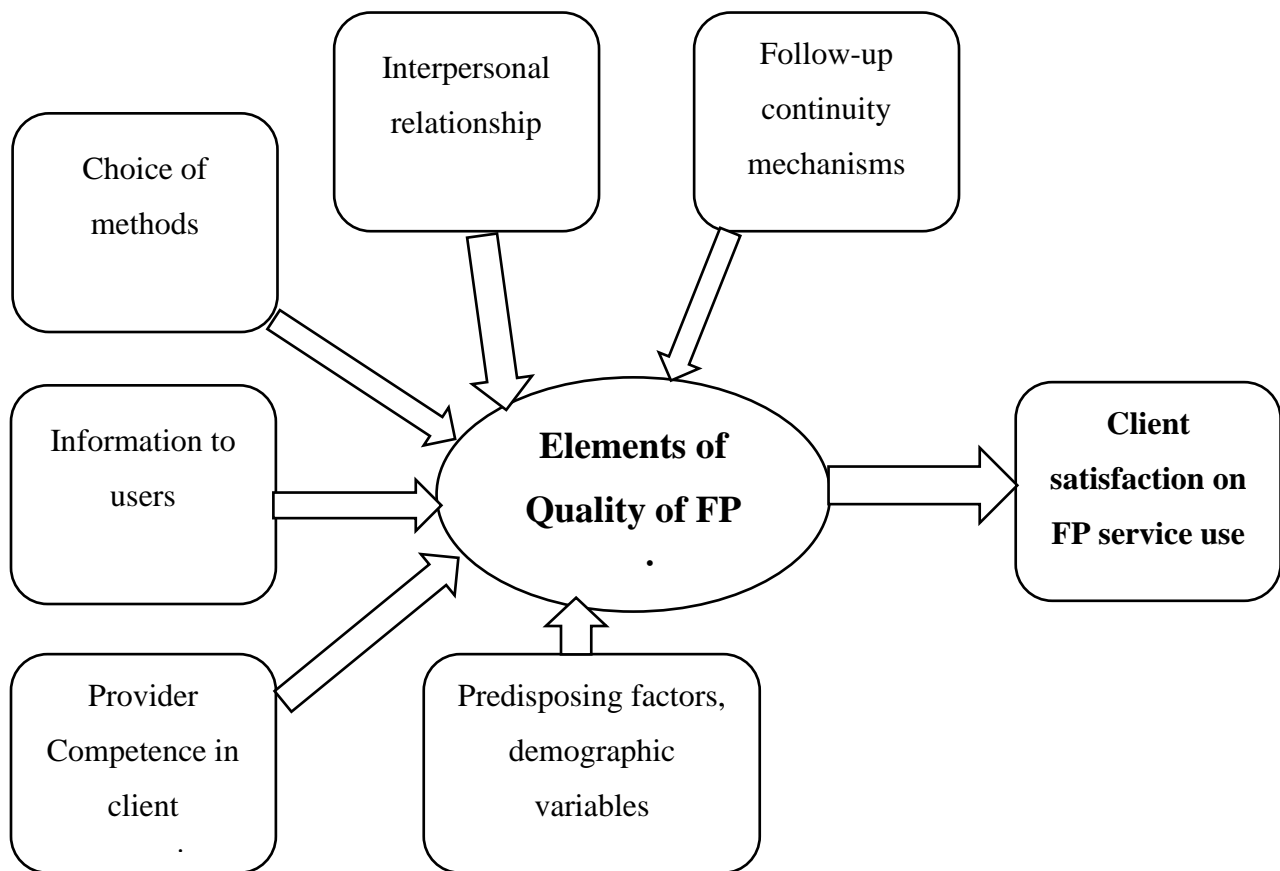
The relationship between marital status and the quality of family planning services was examined in this study. The analysis revealed that being married, divorced, or widowed was associated with a higher perceived of receiving quality family planning services compared to being single. These findings align with previous research conducted by (Smith et al, 2018) in Ethiopia, which also found that married were more likely to receive quality family planning services. However, the association was not statistically significant for single in our study, indicating that being single may not have a significant impact on the quality of family planning services received. This finding differs from the study conducted by (Johnson et al, 2017) in a similar setting, where they reported a significant association between single marital status and lower-quality family planning services. It is important to note that while our study did not find a significant association for single, the sample size for this group was relatively small, which could have influenced the results.

Regarding educational status, our analysis showed that having a primary school or secondary school education was associated with higher odds of receiving quality family planning services compared to having no education. These findings are consistent with the study conducted by (Abebe et al, 2019) in Ethiopia, which also found that higher education levels were associated with better access to quality family planning services. However, the association was not statistically significant for a higher education level in our study, suggesting that the impact of higher education on the quality of family planning services may vary in different contexts.

Examining the source of family planning service, our study found that receiving services from friends was associated with higher odds of receiving quality service compared to obtaining services from husbands/partners, health institutions/HEWs, or through TV/radio. This finding is in line with the research conducted by (Ahmed et al, 2016) in Ethiopia, which emphasized the role of social networks and peer support in improving the quality of family planning services. However, it is worth noting that our study did not find a significant association between receiving services from health institutions/HEWs and the quality of family planning services, which contrasts with the findings of a study conducted by (Ali et al. 2018) in Ethiopia. This difference could be attributed to variations in the availability and accessibility of health services across different regions or settings.

Regarding the sufficiency of information given about the method, our analysis demonstrated that when sufficient information was provided, there was a significantly higher perceived of receiving quality family planning services. This finding aligns with the research conducted by (Gebreselassie et al, 2017) in Ethiopia, which emphasized the importance of comprehensive and accurate information in promoting the quality of family planning services. However, it is noteworthy that the association between information sufficiency and quality service provision was not explored in previous studies reviewed, indicating a gap in the existing literature.

Conceptual framework



A conceptual framework for the study on the status of quality of family planning service (adapted and modified from Judith Bruce, Fundamental elements of Quality of care).

2.3. Synthesis of the Reviewed Literature

Satisfaction is one components of quality health care service. Client satisfaction is a highly relevant signal of the quality of care as it reflects consumers' perceptions of the standards achieved their evaluation of the "goodness" of care, and the success of providers at meeting client values and expectations. Various factors were identified to affect service satisfaction. Despite the fact that service satisfaction is one indicator for quality of the service, it doesn't compressively tell us about the quality of the services. WHO recommend having a comprehensive assessment of the quality of FP services and putting in place a guideline to measure FP quality. Quality of service should be assessed routinely to improve any service gap and provide high standard FP service for women's of reproductive age.

Generally, client satisfaction is an important measure of the quality of service as it provides information on the provider's success in meeting expectations of what is more relevant to the client and an important tools to evaluate administration and planning the process of health care. In Ethiopia, particularly in the study area, no studies showing the clear picture of client satisfaction with family planning has been conducted. Hence, this study is aimed to fill this information gap.

CHAPTER THREE

THE RESEARCH METHODOLOGY

3.1. Study Setting

The study was conducted from March to May 2023, in public health facility, Arada sub-city Addis Ababa, Ethiopia. Arada sub city is located in the central part of Addis Ababa city administration with an estimated 290, 843 population. Of the total population, 52% are females and the rest 48% are males. It has 11 public health centers and 2 governmental hospitals in the sub-city. And from 11 public health centers, 10 health centers are given to routine MCH services currently but 1 health centers are Covid 19 isolation sites. Of the total female population, 23% (34,785) are estimated to be reproductive age groups according to the Arada sub-city health office. It is bordered on the south by Kirkos, on the West by Lideta and Addis Ketema, on the North by Gullele, and East by Yeka(Figure 3.1).

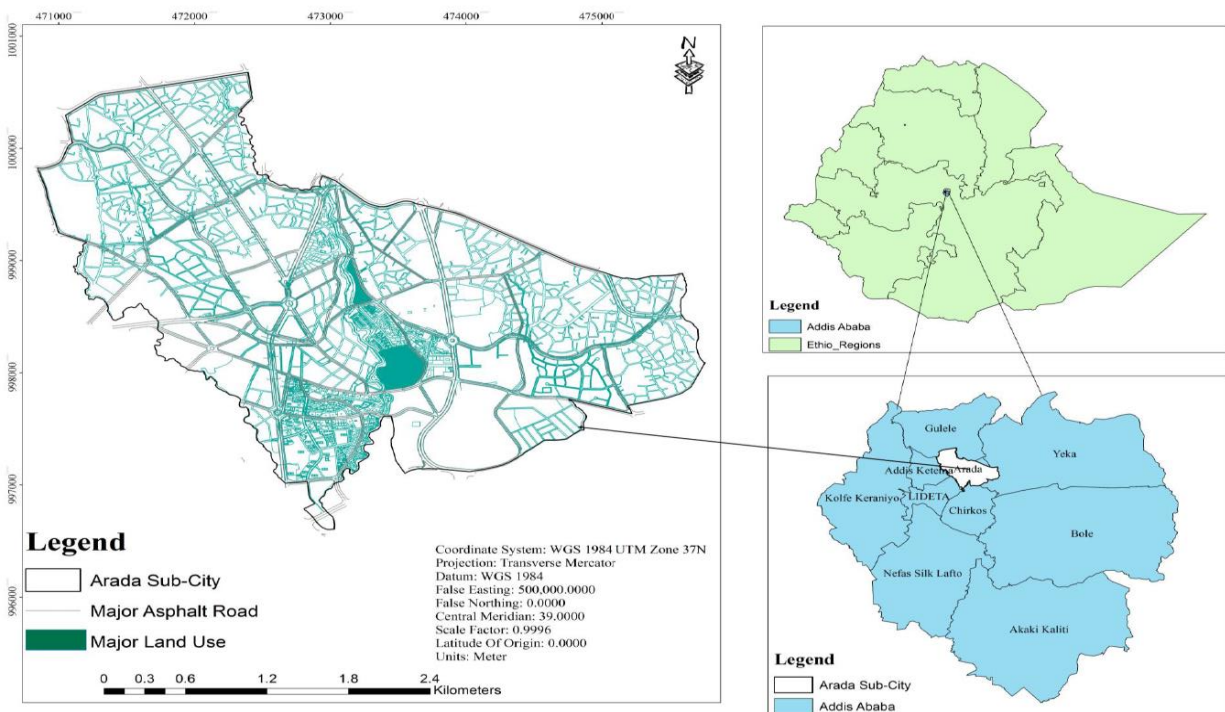


Figure 3. 1. Map of the Study Area (Arada sub-city, Addis Ababa Ethiopia) (Source: Adopted from Arada sub-city Land Administration)

3.2. Study Approach and Design

A health Facility-based cross-sectional study was used. A mixed study design was used to assess the quality of family planning services and its determinants in the Arada sub-city, Addis Ababa, Ethiopia. In order to assess the perception of quality of family planning services, it is important to measure one of the three important components of service quality is the output satisfaction clients. To evaluate it the research was conducted in a health facility-based cross-sectional study. That is why we prefer research, based on health facility-based cross-sectional study. We are interested in measuring service quality at a specific point in time (at the time of data collection), so a cross-sectional study design is best to answer our research question.

3.3. Sampling Technique and Procedure

The study was in ten public health centers found in Arada sub-city for the provision of FPS after listing all the public health facilities to gather adequate information and provide equal opportunity for selection of public health facilities in Arada sub-city Addis Ababa.

3.3.1. Source population

The source population for the study is all reproductive age groups 15 – 49 years of women who are coming to get family planning services, and service providers working at selected study public health facilities.

3.3.2. Study population

Women of reproductive age group 15-49 years attending FPS at the public health centers and fulfill the inclusion criteria in Arada sub-city.

3.3.3. Inclusion and Exclusion criteria

Women of reproductive age group 15-49 years attending public health facilities for family planning health service during the study period were included. FPS clients with an emergency condition, critically ill, health professionals that provide family planning services and health service provider who served less than 2 months were excluded.

3.3.4. Sample Size Determination

To determine the quality of FP services, in 10 health centers that give FPS based on the recommendation of Arada sub-city health office currently giving FP were included. To assess FP service quality, 301 participants were interviewed. The sample size was determined using the following technique.

The sample size for assessing the satisfaction was calculated using a single population proportion formula, considering the following assumptions. From the previous study, the overall client satisfaction to Quality FP service, 76.9% (BeckaTasew, 2017) were used which is reported in a study conducted in Akaki kality sub-city, Addis Ababa, 95% confidence level, and 5% degree of precision.

Sample size is calculated by using single population proportion formula.

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

Where:

n = sample size desired

$Z_{\alpha/2} = 1.96$ (Z=score corresponds to 95% confidence level)

p = 76.9

$d^2 = 0.05$ (Margin of error)

$$n = \frac{(1.96)^2 (0.769 (1 - 0.769))}{0.05^2} = 273$$

For non-response, 10% of contingency added to the sample size= 27.3, then, **the final sample size = 301**

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$Z_{\alpha/2} = 1.96$ (Z =score corresponds to 95% confidence level)

$p = 0.769$

$d^2 = 0.05$ (Margin of error)

$n = \frac{(1.96)^2 (0.769 (1 - 0.769))}{0.05^2} = 273$

0.05^2

For non-response, 10% of contingency added to the sample size= 27.3, then, **the final sample size = 301**

3.4. Study variables

Table 3. 1. Description of the study variables

Dependent variables		
Variable Name	Description	Measures
Outcomes quality	<p>That result is due to the provision of care or client satisfaction (Donabedian A, 1988).The client satisfaction on the provisions of family planning services Satisfaction was assessed as a result of service provider and client interactions. Quality was measured by clients' satisfaction perceptions towards the services provided at the health centers using 25 items questions.</p> <p>In accordance with earlier research, 75% of individuals who received a score of 19 or more were classified as satisfied, while those who had a score of less were classified as dissatisfied.</p>	<p>Clients perception of satisfaction level towards service provided</p> <ul style="list-style-type: none"> ✓ Waiting time, Hours of service provision, cleanliness of facility, staff treatment of client. ✓ Information clarity on methods ✓ Regular availability of methods ✓ quality of examination and treatment provided ✓ Providers' skill in method procedure ✓ Approach friendly
Independent variable		
<p>Socio-demographic factors: Several studies have shown that FP utilization is widely determined by socio-demographic factors. These factors included the age, marital status, number of children,</p>		

and service status of children. The use of FP services is affected by where a woman lives (Andi et al., 2014; Kandala et al., 2015; Medhanyie et al., 2017; Teye, 2017)	
Age	<p>It is the interval of time between the date of birth and the date of the interview, expressed in completed years. Given the differences in life experience between different age groups, as well as people’s changing tastes and behavior as they get older, it can be very useful to include a survey age question.</p> <ol style="list-style-type: none"> 1. 15 -19 years 2. 20 - 24 years 3. 25 – 29 years 4. > 30 years
Marital status	<p>It refers whether a person is legally or culturally married or not</p> <ol style="list-style-type: none"> 1. Single 2. Married 3. Divorced 4. Widowed
Occupation	<p>It measures the respondent’s current working status other than domestic</p> <ol style="list-style-type: none"> 1. Student 2. Employed 3. Housewife 4. Unemployed 5. Others
Socioeconomic and cultural factors: Education and income levels are known to affect FP service use. Women with higher education levels practice FP in several African and Asian countries (Kandala et al., 2015; Wulifan et al., 2016).	
Educational level	<p>It is a measure of the highest level of formal school that the respondent has attended. It was measured as follows</p> <ol style="list-style-type: none"> 1. Can’t read and write 2. Can read and write but no formal education 3. Primary school 4. Secondary school 5. Higher education and above

3.5. Data Collection Tools and Procedures

3.5.1. Quantitative part

The data was collected for two months from FP service delivery points in the Arada sub-city, Addis Ababa. It was collected by interviewing the current reproductive age group of 15 – 49 years who are attending FP service-selected public health facility at Arada sub-city. The question was prepared in the English language and translated into the Amharic language. Qualitative data was used to supplement the quantitative approach with the aim of exploring the barriers to the implementation of the quality of FP health services. So, an Amharic version of the questionnaire was used for the interview. In addition, qualitative data was collected through in-depth interviews with health providers. Two data collectors with BSc nurses who collected this quantitative and qualitative data participated in the data collection of the study. One-day training on study objectives and data collection techniques was provided for both data collectors and supervisors. Each query is complete and consistent.

3.6. Data Analysis Technique

3.6.1. Data quality control

The quality of the data was ensured through careful design, translation, retranslation, and pretesting of the questionnaire. The English version of the questionnaire was adapted and translated to Amharic by language experts. The translated Amharic version were pretested in health facilities out of Arada sub-city public health facilities in 5% of the sample size that is not part of the main study. To ensure data quality, the data collectors were provided a one-day training on the objective of the study, the contents of the questionnaire, and how to maintain the confidentiality and privacy of the study subjects. The data collection process was closely monitored and collected and checked for any incomplete content by the principal investigator.

3.6.2. Analysis and presentation

Data from the questionnaire was cleaned and verified to minimize entry errors, outliers, and missing values. Response from the questionnaire were coded and the codes were saved in the codebook and used during the interpretation. Each variable was checked for missed values. The data entry and analysis were undertaken using SPSS version 24. Descriptive statistics were shown such as frequencies, percentages, and crosstab were used to describe the variables of interest. Bivariate and multivariate regression analysis were conducted to examine the relationship between dependent with independent variables. Finally, odds ratio with a 95% confidence interval along with p-values is used in reporting the results.

3.7. Ethical considerations

Ethical clearance was obtained from Addis Ababa Public Health Research and Emergency Management Directorate and from the concerned institutional research ethics review committee (IRERC) department of population studies at Addis Ababa University (AAU), Formal letters were written to all concerned authorities and permission was secured at all levels. Finally, written informed consent was obtained from the study participants after detailed information was provided about study objectives and assuring confidentiality of the data and participants' autonomy of not to participate or to withdraw at any stage of the interview.

Dissemination of the Results

The result of this study is submitted to Addis Ababa University, College of Development Studies, Center for Population Studies, and Addis Ababa Public Health Research and Emergency Management Directorate.

CHAPTERFOUR

RESULTS AND DISCUSSION

We had a total sample size of 301 Family planning service user clients and 10 health facilities. We collected data from all the samples and health facilities, giving a 100% response rate.

4.1. Descriptive Statistics

4.1.1. Characteristics of respondents

The demographic characteristics and occupational profiles of the respondents. The findings can be further utilized to understand the relationship between these variables and explore patterns or trends within the data. Based on the provided research data, it can be analyzed the distribution of respondents across different variables.

With respect to bio data of the respondents, the majority of respondents fall into the age group of 25-29 years (31.2%), followed by 30-34 years (22.6%) and 20-24 years (17.9%). Respondents aged 15-19 years and above 40 years' account for 12.0% and 12.6% respectively. The smallest proportion of respondents is in the age group of 35-39 years (3.7%).

The largest segment of respondents is married, constituting 40.2% of the total respondents. Single make up 20.9% of the respondents, followed by divorced at 21.3%. Widowed account for 8.0% of the respondents, and 9.6% specified their marital status as "Other."

The majority of respondents have completed secondary school (23.3%) or have attained higher education (23.9%), with no education represent 24.6% of the respondents, while those with primary education (1-8) make up 21.3%. A small proportion of respondents have basic literacy skills (7.0%) or specified "Other" for their education status (9.6%).

The largest occupational category among the respondents is private employees, accounting for 25.2% of the total. Government employees and merchants are the next most common occupations, each representing around 24.6% and 23.9% of the respondents respectively. Unemployed make up 5.0% of the respondents, followed by housewives (10.0%), students (4.0%), and self-employed (6.0%). A small percentage (1.3%) specified "Other" as their occupation.

The income distribution of the respondents shows that the largest group falls within the income range of 1,651-3,200 ETB (25.6%). The second-largest segment is in the income range of 5251-7800 ETB, accounting for 23.6% of the respondents. The proportion of respondents in the other income categories ranges from 9.6% (earning less than 1,650 ETB) to 14.6% (earning more than 10,901 ETB) (Table 4.1).

Table 4. 1. Socio-demographic characteristics of respondents in Arada Sub-city, Addis Ababa, Ethiopia, 2023 (n=301)

Variable Category of variable		Frequency	Percent
Age of the respondents	15 - 19 years	36	12.0
	20 - 24 years	54	17.9
	25 - 29 years	94	31.2
	30 - 34 years	68	22.6
	35 - 39 years	11	3.7
	> 40 years	38	12.6
	Total	301	100.0
Marital Status	Single	63	20.9
	Married	121	40.2
	Divorced	64	21.3
	Widowed	24	8.0
	Other specify	29	9.6
	Total	301	100.0
Education Status	No education	74	24.6
	Read and Write	21	7.0
	Primary School (1-8)	64	21.3
	Secondary School completed	70	23.3
	Higher	72	23.9
	Total	301	100.0
Occupation	Government employee	74	24.6
	Private employee	76	25.2
	Merchant	72	23.9
	Unemployed	15	5.0
	Housewife	30	10.0

	Student	12	4.0
	Self-employee	18	6.0
	Other specify	4	1.3
	Total	301	100.0
Monthly Income	<1,650 ETB	29	9.6
	1,651- 3,200 ETB	77	25.6
	3,201-5,250 ETB	55	18.3
	5,251-7,800 ETB	71	23.6
	7,801-10,900 ETB	25	8.3
	>10,901 ETB	44	14.6
	Total	301	100.0

4.1.2. Clients' information and accessibility to family planning services:

We have assessed family planning service based on the clients' perceptions of quality service output/satisfactions. The analysis of the sources from where respondents heard about the availability of family planning services showed that only 18 (6%) of the respondents mentioned their husband or partner as a source of information about family planning services. This suggests that a relatively small proportion of respondents rely on their spouse or partner for information in this regard. Whereas around 55 (18.3%) of the respondents stated that they hear about family planning services from their friends. This indicates that friends play a significant role in disseminating information and creating awareness about family planning. The majority of respondents 181 (60.1%) reported hearing about family planning services from health institutions or Health Extension Workers (HEWs). This finding suggests that health institutions, clinics, hospitals, and the outreach efforts of HEWs have a strong influence on informing individuals about family planning options. Approximately 47 (15.6%) of the respondents mentioned television and radio as their sources of information regarding family planning services. This indicates that mass media platforms, such as TV and radio programs, are somewhat effective in disseminating information about family planning to a portion of the population.

This analysis reveals that the most prominent source of information about family planning services among the respondents is health institutions and HEWs. It highlights the crucial role played by healthcare providers and community health workers in promoting and educating about family

planning options. Additionally, friends and mass media platforms also contribute to spreading awareness about family planning, albeit to a lesser extent.

Understanding the sources from which receive information about family planning services can help policymakers and healthcare providers target their efforts to reach a wider audience. By strengthening existing channels, such as health institutions and HEWs, and utilizing effective communication strategies through friends and mass media, access to family planning services can be enhanced and knowledge gaps can be addressed.

The majority of respondents 295 (98.0%) reported that it took them between 1/2 to 1 hour to reach the health institution providing family planning services. This suggests that the majority of clients live in relatively close proximity to these facilities, which is positive for accessibility

The substantial percentage of clients 293 (97.3%) who said they were aware of other clinics where they may get family planning services suggests that there is a high level of availability and awareness of other service providers. The implication is that clients have options and can pick the clinic that best meets their needs and preferences. However, there is a small percentage 6 (2.0%) of clients who reported that it took them more than 1 hour to reach the health institution. This may indicate that there are certain areas or populations that face challenges in accessing family planning services due to longer travel distances or transportation limitations

The high percentage of respondents 293 (97.3%) who reported knowing about other clinics where they can receive family planning services indicates that there is a good level of awareness and availability of multiple service providers. This suggests that clients have options and can choose a clinic that best suits their needs and preferences.

A high percentage of clients 295 (98.0%) reported that there were sufficient family planning methods available at the health institution. This suggests that the methods available can meet the diverse contraceptive needs of clients, allowing them to choose the method that aligns with their preferences and requirements.

The majority of clients 196 (65.1%) reported not having to wait or experiencing no waiting time when accessing family planning services. This indicates that the health facility has efficient service delivery, minimizing delays and ensuring prompt access to services. However, a significant percentage of 101 (33.6%) reported short waiting times, suggesting that there is still room for improvement in reducing waiting periods and optimizing the overall service experience for clients.

A very small percentage 4 (1.3%) reported long waiting times, which highlights the importance of addressing any issues causing prolonged waiting periods to ensure a positive and efficient service delivery.

The majority of clients 292 (97.0%) found the health facility's opening hours to be convenient. This indicates that the facility's operating hours align well with the needs and availability of the clients, allowing them to access family planning services without significant inconvenience. However, a small percentage 9 (3.0%) reported that the opening hours were not convenient. It is important to understand the specific reasons behind this perception and explore potential solutions to address any barriers faced by these clients.

These insights provide a deeper understanding of the client's experiences and perceptions regarding the accessibility and quality of family planning services. By addressing any identified challenges and building upon the strengths, efforts can be made to ensure that family planning services are easily accessible, well-informed, and meet the needs of the clients effectively (**Table 4.2**).

Table 4. 2. Clients' access to health facilities and information about family planning services in Arada Sub city, Addis Ababa, Ethiopia 2023 (n=301).

Variable	Category of variable	Frequency	Percent
From where do you hear about the source of family planning services?	Husband/partner	18	6.0
	Friends	55	18.3
	Health institution/HEW	181	60.1
	TV/Radio	47	15.6
How long did it take you to arrive from your home at this health institution?	1/2 to 1 hours	295	98.0
	above 1 hour	6	2.0
Do you know any other clinic where you can get a family planning service?	Yes	293	97.3
	No	7	2.3
Sufficient methods were available.	Yes	295	98.0
	No	6	2.0
How do you feel about your waiting time?	No waiting	196	65.1
	Short	101	33.6
	Long	4	1.3

Are health facility opening hours convenient?	Yes	292	97.0
	No	9	3.0

4.1.3. Types and percentage of contraceptive methods frequently used by clients

The analysis of the percentage distribution of who accepted family planning methods in ten service delivery points in Arada Sub-city showed that 40 (13.3%) of the respondents opted for contraceptive pills as their chosen family planning method. This indicates that a significant proportion prefer this method, which offers convenience and ease of use. 28 (9.3%) of the respondents chose the Intrauterine Contraceptive Device (IUCD) as their preferred family planning method. This method involves the insertion of a small device into the uterus and provides long-term protection against pregnancy. Only 2 (0.7%) of the respondents selected condoms and opted for female sterilization (which is a permanent contraceptive method involving surgical intervention) as their family planning method.

Condoms are a barrier method that not only prevents pregnancy but also provides protection against sexually transmitted infections (STIs). The highest proportion of respondents 88 (29.2%) chose injectable contraceptives as their preferred method. Injectable contraceptives were administered via an injection and provide long-acting protection against pregnancy. The majority of respondents 141 (46.8%) chose Implanon, which is a long-acting reversible contraceptive implant inserted under the skin. Implanon offers an extended period of contraceptive protection.

However, it is worth noting that the distribution of contraceptive methods can vary across regions and countries due to cultural, socioeconomic, and healthcare system differences. It is common to see variations in contraceptive method preferences based on factors such as accessibility, awareness, cultural beliefs, and individual preferences.

Additionally, it is important to consider that family planning program implementation, promotion, and access to various contraceptive methods may have evolved over time, leading to changes in method preferences. Comparative analysis with previous research can help identify these changes and provide valuable information for policy-making and program implementation in the field of family planning (**Figure 4.1**).

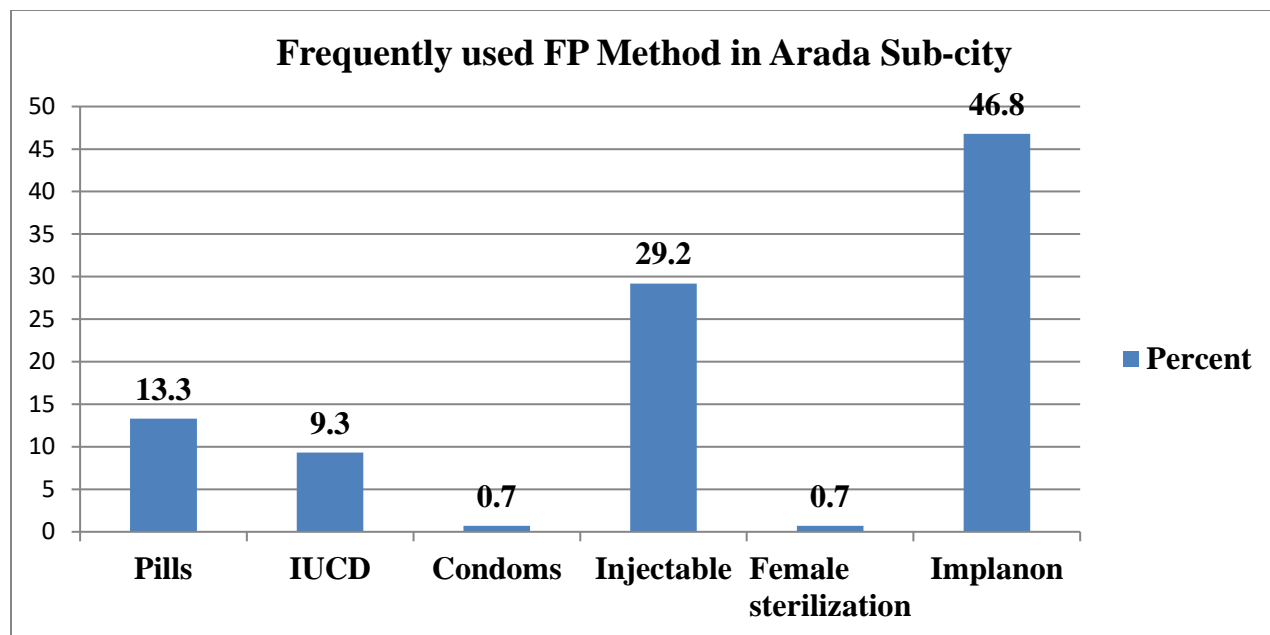


Figure 4. 1. Types of contraceptive methods frequently used by clients in assessing the quality of services in family planning services among public health facilities in Arada Sub-city, Addis Ababa, Ethiopia 2023

4.1.4. Provider competency for provision of family planning service

4.1.4.1. Information given to the client by service provider

Based on the given data analysis reveals that 236 (78.5%) of clients reported receiving a demonstration on how to use FP methods indicates that a significant majority of clients were provided with practical guidance on the correct usage of the methods. This suggests that the healthcare providers took the time to educate and train clients on the proper implementation of family planning, and describe the possible side effects of FP is encouraging to see that 299 (99.3%) of clients were informed about the possible side effects of family planning. This demonstrates a responsible approach by the healthcare providers in ensuring that clients are aware of the potential consequences or adverse effects associated with the chosen FP methods. This information enables clients to make informed decisions and be prepared for any potential challenges.

The high percentage 297 (98.7%) of respondents being informed about the possibility of changing the method if they are not satisfied indicates that the healthcare providers or counselors emphasized client choice and autonomy. By providing information about alternative methods and the flexibility to switch if necessary, they acknowledge that different methods may suit different individuals and situations. This approach promotes client satisfaction and increases the perceived of finding a method that aligns with their needs and preferences.

The data shows that 294 (97.7%) of clients received a demonstration on how to use family planning. This indicates a commitment to ensuring that clients have practical knowledge and skills to effectively utilize their chosen FP methods. By demonstrating the correct usage, healthcare providers improve the chances of successful implementation and reduce the potential for incorrect or ineffective use. While the majority 233 (77.5%) of clients found the information given about the method to be sufficient, it is worth noting that 68 (22.5%) of clients felt the information was inadequate. This suggests that there is room for improvement in the clarity and comprehensiveness of the information provided to clients. Healthcare providers may need to assess and address the factors contributing to this dissatisfaction to ensure that clients have a complete understanding of the chosen method.

An overwhelming majority 299 (99.3%) of clients reported being informed about other methods besides the one they received. This demonstrates a comprehensive approach to family planning counseling, where clients are presented with a range of options and information to make an informed decision. By providing information about alternative methods, healthcare providers enable clients to consider various options and select the one that best suits their needs and preferences (**Table 4.3**).

Table 4. 3. Information given to the client by service provider in Arada Sub-city, Addis Ababa, Ethiopia, 2023

Variable	Category of variable	Frequency	Percent
Did demonstrate how to use FP methods?	Yes	236	78.5
	No	65	21.5
Describe possible side effects FP.	Yes	299	99.3
	No	2	0.7
Explains the possibility of changing the method if you are not happy with it.	Yes	297	98.7
	No	4	1.3
Demonstrate how to use family planning methods?	Yes	294	97.7
	No	6	2.0
Information given about the method was sufficient.	Yes	233	77.5
	No	68	22.5
In addition to the method you received, were you told about any other methods?	Yes	299	99.3
	No	2	0.7

Overall, the data analysis indicates that while there are areas of strength in the information provided to clients, there is also room for improvement in ensuring that all clients receive sufficient and comprehensive information about their chosen family planning methods. This can help empower individuals to make well-informed decisions and enhance their overall satisfaction with the chosen method.

4.2. Perception of clients on the process of obtaining the services

The data analysis shows that, 297 (98.7%) of clients felt that their consultation with the service provider was about the right length, indicating that they were satisfied with the duration of their interaction. This suggests that the consultations were neither too short nor too lengthy, meeting the clients' expectations. Moreover, 283 (94.0%) of clients found the service provider easy to understand during the consultation. This indicates that the majority of clients felt that the provider effectively communicated information and instructions in a clear manner.

A smaller percentage of clients 12 (4.0%) reported finding it difficult to understand the provider, while 4 (1.3%) stated that they did not understand. It's important to address these issues to enhance communication and ensure that clients fully comprehend the information provided.

The analysis of the respondents' decision to use a contraceptive method at the visit, based on the provided data revealed that the majority of respondents 293 (97.7%) reported that they decided to use a contraceptive method during their visit to the clinic. This indicates a high level of acceptance and intention to use contraception among the respondents, reflecting a positive attitude towards family planning. Only a small proportion of respondents 7 (2.3%) stated that they did not decide to use a contraceptive method during their visit. This suggests that a minority is either opted not to use contraception at that particular time or might have different plans or considerations regarding family planning.

Overall, the analysis indicates a strong inclination towards using contraceptive methods among the respondents. The high percentage who decided to use a contraceptive method reflects a positive impact of the clinic visit in terms of promoting family planning and enabling informed decision-making.

The intentions to get the service again, 221 (73.4%) of clients expressed their intention to return for their next visit, indicating that they were satisfied with the services received and willing to continue utilizing the facility for their family planning needs, 80 (26.6%) of clients responded "NO" when

asked if they would come back for the next visit. This suggests that a portion of clients may not be inclined to return, and it would be valuable to explore the reasons behind their decision to better understand their concerns and address any potential issues (**Table 4.4**).

Table 4. 4. Perception of clients on the process of obtaining services at public health center in Arada Sub-city, Addis Ababa, Ethiopia, 2023

Variable	Category of variable	Frequency	Percent
Did you feel that your consultation with the service provider	About right	297	98.7
	Too short	4	1.3
During consultation, was the provider easy to understand?	Easy to understand	283	94.0
	Difficult to understand	12	4.0
	Don't understand	4	1.3
	No answer	2	0.7
Did you decide to use a contraceptive method at this visit?	Yes	294	97.7
	No	7	2.3
	Total	301	100.0
Will you comeback for the next visit	Yes	221	73.4
	No	80	26.6

These insights provide an understanding of the clients' perception of the consultation process and their intentions to continue utilizing the services. The high satisfaction rate regarding the consultation duration and ease of understanding indicates positive experiences overall. However, it is crucial to address any difficulties in understanding and explore the reasons behind the clients' decision not to return in order to improve service quality and ensure client retention.

Clients informed about the possible side effects combined oral contraceptive pills (OCP) of family planning methods.

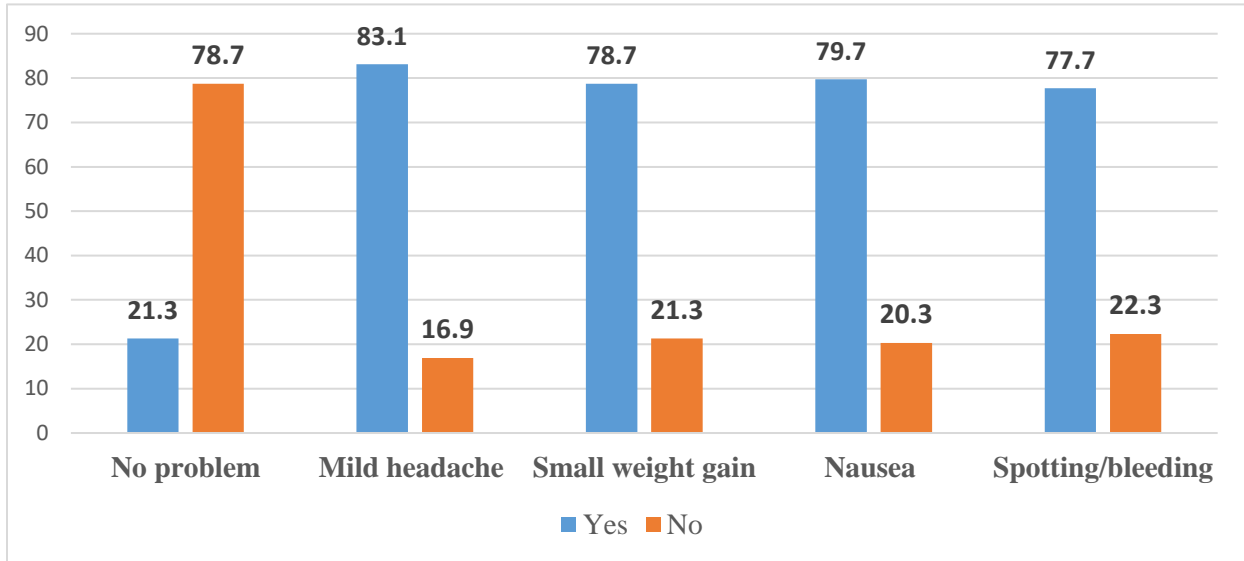


Figure 4. 2. Minor problems of OCP family planning methods of pills in Arada Sub-city, Addis Ababa, 2023

The analysis shown on the above **Figure 4.2**, of the respondents' (40) from pills user of 40 reported problems with contraceptive pills, based on the findings showed that 31 (78.7%) answered "No" when asked if they experienced form problems with contraceptive pills, while 6(21.3%) answered "Yes." This suggests that a significant proportions with no encountered issues related to the form of the contraceptive pills they were using. Among the respondents asked about Mild headaches, 33 (83.1%) answered "yes" when asked if they experienced mild headaches while using contraceptive pills, while 7(16.9%) answered "no." This indicates that a large majorities reported experiencing mild headaches as a side effect of using contraceptive pills.

With regard to small weight gain, similarly, 31 (78.7%) of the respondents stated that they experienced small weight gain while using contraceptive pills, while 6 (21.3%) reported no weight gain. This suggests that a significant proportion of individuals perceived a slight increase in their body weight as a result of using contraceptive pills.

Moreover, the pills usage has also brought nausea and the finding showed that 32 (79.7%) of the respondents experienced nausea as a side effect of using contraceptive pills, while 8 (20.3%) did not. This indicates that a considerable number are faced episodes of nausea while using contraceptive pills.

Finally, 31 (77.7%) experienced spotting or bleeding while using contraceptive pills, while 9(22.3%) didn't. Spotting or irregular bleeding between menstrual periods is a known side effect of contraceptive pills, and the data indicates that a significant proportion encountered this issue.

Overall, the analysis reveals that a considerable number of respondents experienced various problems while using contraceptive pills. These problems include form issues, mild headaches, small weight gain, nausea, and spotting/bleeding. It is important to note that these reported problems may vary in intensity and impact among individuals.

These findings highlight the need for healthcare providers and family planning programs to educate individuals about the potential side effects of contraceptive pills and to offer appropriate counseling and support. By addressing these reported problems and providing accurate information, healthcare providers can help individuals make informed decisions about contraceptive methods and manage any side effects effectively.

4.3. Satisfaction of clients on FP service provided

The majority of respondents 249 (82.8%) of the respondents thought the provider had adequate expertise and competence to carry out the procedure. This shows that the majority of patients trusted the knowledge of their healthcare professional, which is crucial for guaranteeing the effectiveness and quality of the family planning service.

While 235 (78.0%) of respondents said they were handled with friendliness and respect, it is noteworthy that 22.0% of them did not. This implies the need for healthcare professionals and providers to be aware of customer interactions and general demeanour. An environment that is encouraging and respectful can enhance the client's experience and satisfaction. Moreover, 275 (91.4%) clients said they had enough visual and aural privacy during the session. This demonstrates that the healthcare facility has policies and procedures in place to safeguard client privacy and improve their comfort while having family planning-related conversations. The protection of privacy is essential for encouraging honest dialogue and mutual trust between customers and service providers.

Whereas 236 (78.5%) of the clients thought the information provided on the procedure was adequate, it's important to note that 65 (21.5%) thought it was insufficient. This means that healthcare providers must make sure that patients receive thorough and understandable information regarding the family planning strategy they have chosen. Enhancing the quality of the information provided to

clients can help them make wise decisions and increase their satisfaction with the service. Almost all of the 297 (98.7%) thought they got the chance to ask questions and look for clarification. This shows that there is a supportive environment in place that supports client engagement and active participation in their reproductive health care. Clearing up client questions and issues can reduce uncertainty and boost general satisfaction

The data shows that 297 (98.7%) of clients received a reminder mechanism for their next visit. This indicates that the healthcare facility has implemented systems to enhance client follow-up and continuity of care. Reminders can help clients stay on track with their family planning needs, ensuring they receive timely and appropriate services.

The majority of clients 279 (92.7%) said that the health facility was clean. This suggests that the healthcare facility maintains a hygienic environment, which is essential for the prevention of infections and promoting a sense of safety and well-being among clients. Regular maintenance and adherence to cleanliness protocols contribute to a positive overall experience.

While 223 (74.1%) of clients said other staff members treated them with kindness and respect, a large portion, 78 (25.9%), did not have a similar experience. Throughout the client's relationship with the institution, it is critical for all staff members to uphold professional standards of conduct and foster a supportive environment. Overall client satisfaction can be increased by addressing any issues with employee behaviour and making sure everyone is treated with respect

The majority of 221 (75.2%) thought their family planning services were of a high standard. It's important to note, though, that 80 (24.8%) people had different opinions. This emphasizes the requirement for healthcare facilities and professionals to consistently evaluate and increase the quality of care delivered, addressing any issues or potential improvement areas raised by patients **(Table 4.5)**.

Table 4. 5. Perception Satisfaction of clients on FP service in Arada Sub-city, Addis Ababa, Ethiopia, 2023

Variable	Yes (%)	No (%)
The provider has good knowledge and skills to perform the procedure.	249 (82.8)	52 (17.2)
Were you treated in a friendly and respectful way?	235 (78.0)	66 (22.0)
You had sufficient visual and auditory privacy during your consultation.	275 (91.4)	26 (8.6)

The Information given about the method was sufficient.	236 (78.5)	65 (21.5)
Did you feel that you had the opportunity to ask questions and clarity?	297 (98.7)	4 (1.3)
The provider gave you a reminder mechanism for your next visit.	297 (98.7)	2 (0.7)
The health facility was clean.	279 (92.7)	22 (7.3)
Treated in a friendly and respectful way by other staff.	223 (74.1)	78 (25.9)
Will you come back for the next visit?	221 (73.4)	80 (26.6)
Did you agree that over all you have received a good quality FP service and satisfied?	226 (75.2)	75 (24.8)

In summary, while the satisfaction data shows positive trends in several areas, such as provider knowledge, privacy, and the opportunity for client engagement, there are also areas for improvement, including interpersonal interactions, information provision, and facility cleanliness. By addressing these areas, healthcare providers and facilities can enhance the overall quality of family planning services and improve client satisfaction, ultimately leading to better reproductive health outcomes.

4.4. Constellation of services

The high percentage of respondents 295(98.0%) who indicated that FP methods are frequently available implies that people consistently have access to a range of FP options. This is an excellent outcome since it shows that efforts have been made to provide a steady supply of FP procedures, allowing people to make educated decisions about their reproductive health. There is potential for improvement, even if a significant proportion of respondents 236 (78.5%) said the material about FP approaches was clear. The fact that 65(21.5%) of respondents believed the material wasn't clear enough points to the need for more education and communication on FP techniques. Making information accessible and understandable can help people make well-informed decisions and gain a better grasp of their options.

It is a good finding that 294 (97.7%) of respondents felt that providers were skilled in performing FP procedures. It shows that the healthcare professionals providing FP services have the knowledge and skills required to ensure secure and efficient procedures. For the FP services to remain safe and of high quality, this advanced degree of expertise is essential.

The majority of respondents, 235 (78.0%), believed that FP services were approached in a respectful manner, which is a positive indicator of the general experience individuals have when seeking FP guidance. A welcoming attitude fosters a supportive and judgment-free environment, which may encourage individuals to seek FP treatments without hesitating or worrying about being stigmatized.

Even though a substantial proportion of respondents (74.0%) said that FP processes were clean, the 26.0% who voiced concerns regarding cleanliness indicate that this issue needs to be addressed.

For the purpose of preventing infections and preserving the general safety and hygienic conditions of the service delivery environment, it is essential to ensure cleanliness during FP processes. Taking care of these issues and keeping strict standards of hygiene is crucial for offering outstanding FP services.

The process to obtain FP services was considered to be quick by the majority of respondents (65.1%), indicating that it is regarded as efficient. The 34.9% of respondents who felt the process was too lengthy, however, should be taken into account since this may point to possible areas for improvement. Accessibility may be increased, and clients will be more satisfied, by optimizing the procedure and reducing any unnecessary delays.

The majority of respondents (75.2%) gave the FP component's overall quality a good evaluation, indicating that they were generally happy with the services they received. It is important to note that 24.8% of respondents had a less positive opinion of the overall quality, which may indicate that there are certain areas that need improvement. To close any gaps found and guarantee continuously high-quality FP services, ongoing quality improvement initiatives must be taken into consideration.

These findings highlight both the strengths and areas for improvement within the FP component. They provide valuable insights for policymakers, healthcare providers, and organizations involved in reproductive health to focus on areas such as information dissemination, provider training, service efficiency, cleanliness standards, and overall quality improvement initiatives. By addressing these aspects, the quality of FP services can be further enhanced, resulting in improved reproductive health outcomes for individuals and communities

Table 4. 6. Overall client satisfactions on quality of family planning services in Arada sub city, Addis Ababa, Ethiopia, 2023 (n=301).

Quality FP component	Yes (%)	No (%)
Regular availability of methods	295 (98.0)	6(2.0)
Information clarity on methods	236(78.5)	65(21.5)
Providers' skill in method procedure	294(97.7)	6(2.3)
Approach friendly	235(78)	66(22)
Procedures cleanliness	223(74)	78(26)
Shortness of the process to get the service	196(65.1)	105(34.9)
Overall quality satisfaction	226 (75.2)	80 24.8)

4.5. Perceived Quality of Family planning Services

We have assessed the family planning service based on the perception of the client's on the quality of services provided in terms of satisfactions. The data shows that 75.2% of facilities had good output quality/satisfaction ratings based on the satisfaction level. This suggests that the majority of clients receiving family planning services in these facilities reported a satisfactory experience. It is important to note that 24.8% of facilities received poor quality ratings, indicating areas where client expectations were not fully met. Understanding the underlying reasons for this dissatisfaction is crucial in order to address the gaps and improve the overall client experience.

4.6. Clients level of Satisfaction and Determinants of Family planning Service.

In the analysis, we were investigated the sociodemographic determinants of family planning service satisfaction among clients attending Family Planning Services (FPS) in Arada Sub-city, Addis Ababa. The variables examined in relation to service satisfaction were marital status, educational status, source of information for FP service, waiting time adequacy, and availability of sufficient methods.

4.7. Factors Associated with client satisfaction of Family planning services

Table 4. 7. Bivariate analysis

Variable s	Categories	Satisfaction on Family planning Service		COR	95% CI	P- Value
		Yes	No			
Marital Status	Single	51	12	1		
	Married	89	32	3.176	(0.66, 15.237)	0.149
	Divorced	40	24	4.854	(1.09, 21.582)	0.038*
	Widowed	14	10	8.100	(1.767, 37.141)	0.007*
	Other Specify	27	2	9.643	(1.852, 50.196)	0.007*
Educational status	No education	60	14	1		
	Read and write	16	5	1.167	(0.499, 2.730)	0.722
	Primary School	41	23	1.562	(0.480, 5.085)	0.459
	Secondary school	44	26	2.805	(1.256, 6.261)	0.012*
	Higher	60	12	2.955	(1.345, 6.490)	0.007*
Source of information of FP service	Husband/Partner	8	10	1		
	Friends	43	12	5.278	(1.622, 17.175)	0.006*
	Health institution/HEW	132	49	1.178	(0.447, 3.103)	0.740
	TV/Radio	38	9	1.567	(0.706, 3.478)	0.269
Waiting time was adequate	Yes	171	73	1		
	No	50	7	3.049	(1.320, 7.043)	0.009*

Variable s	Categories	Satisfaction on Family planning Service		COR	95% CI	P- Value
		Yes	No			
Sufficient methods were available	Yes	168	72	1		
	No	53	8	2.839	(1.285, 6.275)	0.010*
Information given about the method was sufficient	No	51	8	1		
	Yes	170	72	2.700	(1.220, 5.977)	0.014*
The waiting area was comfortable?	Yes	169	73	1		
	No	52	7	3.209	(1.392, 7.399)	0.006*

Key * indicated significant association

Marital Status: The categories of divorced, widowed, and other specified marital status showed a significant positive association with quality family planning service satisfaction compared to the reference category of single. The odds ratios (OR) and adjusted odds ratios (AOR) for these categories were consistently higher than 1, indicating a higher perceived of reporting satisfaction with service quality.

Educational Status: Respondents with secondary school education and higher education reported significantly higher levels of satisfaction with family planning service quality compared to those with no education. The OR and AOR for these categories were consistently higher than 1, indicating a positive association.

Source of Information for FP Service: Clients who received information about family planning from friends reported significantly higher satisfaction levels compared to those whose source of information was their husband/partner. The OR and AOR for this category were higher than 1, indicating a positive association.

Availability of Sufficient Methods: The availability of sufficient methods showed a significant positive association with family planning service satisfaction. Clients who reported that sufficient

methods were not available had higher odds of being dissatisfied with service quality. The OR and AOR for "No" compared to "Yes" were higher than 1, indicating a positive association. The findings highlight the sociodemographic factors that may influence family planning service satisfaction, providing insights for improving service delivery and addressing client needs.

In Bivariate logistic regression analysis marital status, educational status, source of FP service, adequacy of waiting time, sufficient methods were available, sufficient information given about the method, waiting area comfortably, were found to be significantly associated with quality family planning service.

The relationship between marital status and the quality of family planning service. In this group, the variable is Marital Status the category was Single, Married, Divorced, Widowed, Other Specify. This was analyzed on the Quality family planning service with response (Yes or No). The COR Measure of association (Crude Odds Ratio), 95% CI: 95% Confidence Interval for the COR and P-Value (Statistical significance level for the association) is presented in **Table 4.7** above. The findings showed that for Marital Status (Single) the respondents responded Yes for Quality family planning service (51) and who are responded No (12), with (COR= 3.176), 95% Confidence Interval (0.66, 15.237) and significant level (P-Value= 0.149). The crude odds ratio (COR) for single receiving quality family planning service compared to those who don't is 3.176. However, this association is not statistically significant at the conventional significance level of 0.05 (P-Value = 0.149). The 95% confidence interval suggests that the true odds ratio lies between 0.66 and 15.237.

The findings showed that for Marital Status (Single) the respondents responded Yes for Quality family planning service (89) and who are responded No (32), with (COR= 4.854), 95% Confidence Interval (1.09, 21.582) and significant level (P-Value= 0.038). The crude odds ratio (COR) for single receiving quality family planning service compared to those who don't is 3.176. Therefore, for married, the COR is 4.854, indicating a higher odd of receiving quality family planning service compared to those who don't. This association is statistically significant at the 0.05 significance level (P-Value = 0.038). The 95% confidence interval suggests that the true odds ratio lies between 1.09 and 21.582.

The findings showed that for Marital Status (Married) the respondents responded Yes for Quality family planning service (40) and who are responded No (24), with (COR= 8.100), 95% Confidence Interval (1.767, 37.141) and significant level (P-Value= 0.007). The crude odds ratio (COR) for Married receiving quality family planning service compared to those who don't is 3.176. Divorced

have a COR of 8.100, indicating a significantly higher odd of receiving quality family planning service compared to those who don't (P-Value = 0.007). The 95% confidence interval suggests that the true odds ratio lies between 1.767 and 37.141.

The findings showed that for Marital Status (Widowed) the respondents responded Yes for Quality family planning service (14) and who are responded No (10), with (COR= 9.643), 95% Confidence Interval (1.852, 50.196) and significant level (P-Value= 0.007). The crude odds ratio (COR) for widowed receiving quality family planning service compared to those who don't is 3.176. Widowed have the highest COR of 9.643, indicating a significantly higher odd of receiving quality family planning service compared to those who don't (P-Value = 0.007). The 95% confidence interval suggests that the true odds ratio lies between (1.852 and 50.196). Based on the analysis, being married, divorced, or widowed appears to be associated with a higher perceived of receiving quality family planning service compared to being single. However, the association is statistically significant only for married, divorced, and widowed.

Examining the source of family planning service, it was found that receiving family planning services from health institutions or health extension workers (HEW) was associated with a significantly higher perceived of quality service provision compared to obtaining services from husbands/partners, friends, or through TV/radio. The AOR for health institution/HEW was 3.742, with a 95% confidence interval (CI) of (1.071, 13.070), and a p-value of 0.039. Regarding the availability of sufficient methods, there was no statistically significant association between the presence of sufficient methods and the quality of family planning service. The AOR was 0.805, indicating a slight decrease in the odds of quality service provision when sufficient methods were available. The 95% CI was (0.401, 1.614), with a p-value of 0.541.

Lastly, concerning the sufficiency of information given about the method, it was found that when the information given about the method was sufficient, there was a significantly higher perceived of receiving quality family planning service. The AOR was 2.613, with a 95% CI of (1.110, 6.155), and a p-value of 0.028. These findings suggest that marital status, educational status, source of family planning service, and sufficiency of information play important roles in the provision of quality family planning services. Healthcare providers and policymakers should consider these factors when designing interventions to ensure equitable access and delivery of high-quality family planning services.

Table 4. 8. Multivariate analysis

Variable s	Categories	Satisfaction on Family planning Service		AOR	95% CI	P- Value
		Yes	No			
Marital Status	Single	51	12	1		
	Married	89	32	3.567	(0.702, 18.130)	0.125
	Divorced	40	24	5.274	(1.104, 25.203)	0.037*
	Widowed	14	10	8.547	(1.759, 41.538)	0.008*
	Other Specify	27	2	10.861	(1.942, 60.748)	0.007*
Educational status	No education	60	14	1		
	Read and write	16	5	1.314	(0. .534, 3.233)	0.552
	Primary School	41	23	1.621	(0.448, 5.863)	0.461
	Secondary school	44	26	3.200	(1.349, 7.590)	0.008*
	Higher	60	12	3.286	(1.420, 7.607)	0.005*
Source of information about FP service	Husband/Partner	8	10	1		
	Friends	43	12	3.742	(1.071, 13.070)	0.039*
	Health institution/HEW	132	49	1.128	(0. .398, 3.202)	0.821
	TV/Radio	38	9	1.366	(0.577, 3.231)	0.478
Sufficient methods were available	Yes	168	72	1		
	No	53	8	0.805	(0.401, 1.614)	0.541

Variable s	Categories	Satisfaction on Family planning Service		AOR	95% CI	P- Value
		Yes	No			
Information given about the method was sufficient	No	51	8	1		
	Yes	170	72	2.613	(1.110, 6.155)	0.028*

Key * indicated significant association

In the multivariate logistic regression shown in Table 4.8, the analysis variables which had significantly associated with quality family planning service in the bivariate analysis except sufficient methods were available. The finding showed that for the category "Single," there were 51 respondents who responded "Yes" for quality family planning service and 12 respondents who responded "No." The adjusted odds ratio (AOR) for single receiving quality family planning service compared to those who don't is 3.567. The category "Single" is used as the reference category (AOR= 1).

The 95% confidence interval suggests that the true odds ratio lies between 0.702 and 18.130. whereas for the category "Married," there were 89 respondents who responded "Yes" for quality family planning service and 32 respondents who responded "No." The AOR for married is 5.274, indicating higher odds of receiving quality family planning services compared to those who don't. This association is statistically significant at the 0.05 significance level (p-value = 0.0125). The 95% confidence interval suggests that the true odds ratio lies between 1.104 and 25.203. Married have an AOR of 3.567, indicating a 3.567 times higher odds of receiving quality family planning services compared to the reference category. However, this association is not statistically significant at the conventional significance level (p-value = 0.125).

For the category "Divorced," there were 40 respondents who responded "Yes" to quality family planning service and 24 respondents who responded "No." The AOR for divorced is 8.547, indicating significantly higher odds of receiving quality family planning services compared to those who don't (p-value = 0.037). The 95% confidence interval suggests that the true odds ratio lies between 1.759 and 41.538. The AOR for the Divorced category is 8.547, with a 95% CI of (1.759, 41.538) and a p-value of 0.037. This suggests that divorced have significantly higher odds of

receiving quality family planning services compared to single Divorced have an AOR of 5.274, indicating a 5.274 times higher odds of receiving quality family planning services compared to the reference category. This association is statistically significant (p -value = 0.037).

For the last category "Widowed," there were 14 respondents who responded "Yes" for quality family planning service and 10 respondents who responded "No." The AOR for widowed is 10.861, indicating the highest odds among all marital status categories. This association is statistically significant (p -value = 0.008), and the 95% confidence interval suggests that the true odds ratio lies between 1.942 and 60.748. Widowed: The AOR for the Widowed category is 10.861, with a 95% CI of (1.942, 60.748) and a p -value of 0.008. This indicates that widowed have the highest odds of receiving quality family planning services compared to single Widowed have an AOR of 8.547, indicating an 8.547 times higher odds of receiving quality family planning services compared to the reference category. This association is statistically significant (p -value = 0.008). The category "Other Specify" has an AOR of 10.861, indicating a 10.861 times higher odds of receiving quality family planning services compared to the reference category. This association is statistically significant (p -value = 0.007). The researcher needs to consider the category for future research

With regard to Educational Status, the category "No education," there were 60 respondents who responded "Yes" for quality family planning service and 14 respondents who responded "No." The AOR for with no education is 1.314, indicating slightly higher odds of receiving quality family planning service compared to those who don't. The 95% confidence interval suggests that the true odds ratio lies between 0.534 and 3.233.

However, for those "Read and write," there were 16 respondents who responded "Yes" for quality family planning service and 5 respondents who responded "No." The AOR for who can read and write is 1.621, indicating slightly higher odds, but this association is not statistically significant (p -value = 0.461). The 95% confidence interval suggests that the true odds ratio lies between 0.448 and 5.863.

Those who have "Primary School," education level, there were 41 respondents who responded "Yes" for quality family planning service and 23 respondents who responded "No." The AOR for with a primary school education is 3.200, indicating higher odds of receiving quality family planning service compared to those who don't. This association is statistically significant (p -value = 0.008). The 95% confidence interval suggests that the true odds ratio lies between 1.349 and 7.590. Similar to the primary education, for the category "Secondary school," there were 44 respondents who

responded "Yes" for quality family planning service and 26 respondents who responded "No." The AOR with a secondary school education is 3.286, indicating higher odds of receiving quality family planning service compared to those who don't. This association is statistically significant (p-value = 0.005). The 95% confidence interval suggests that the true odds ratio lies between 1.420 and 7.607. However, the category "Higher," there were 60 respondents who responded "Yes" for quality family planning service and 12 respondents who responded "No." The AOR with a higher education is 3.286, indicating higher odds of receiving quality family planning service compared to those who don't. However, this association is not statistically significant (p-value = 0.005). The 95% confidence interval suggests that the true odds ratio lies between 1.420 and 7.607.

Considering the category "No education" as the reference category (AOR = 1). Read and write, Primary School, Secondary school, and Higher educational levels are compared to the reference category. None of the educational categories show a statistically significant association with the quality of family planning services. The AOR values for all categories are greater than 1, indicating a higher odds compared to the reference category, but the associations are not statistically significant.

While for the Source of FP Service, respondents who have got information from "Husband/Partner," there were 8 respondents who responded "Yes" for quality family planning service and 10 respondents who responded "No." The AOR receiving family planning services from their husband/partner is 1, indicating no difference in the odds of receiving quality service compared to those who don't. The findings showed that "Friends," as a source of FP services. There were 43 respondents who responded "Yes" for quality family planning service and 12 respondents who responded "No." The AOR receiving family planning services from friends is 3.742, indicating higher odds of receiving quality service compared to those who don't. This association is statistically significant (p-value = 0.039). The 95% confidence interval suggests that the true odds ratio lies between 1.071 and 13.070.

Considering the "Health institution/HEW" (Health Extension Worker), there were 132 respondents who responded "Yes" for quality family planning service and 49 respondents who responded "No." The AOR receiving family planning services from health institutions or health extension workers is 1.128, indicating no significant difference in the odds of receiving quality service compared to those who don't (p-value = 0.821). The 95% confidence interval suggests that the true odds ratio lies between 0.398 and 3.202. Last category "TV/Radio," there were 38 respondents who responded "Yes" for quality family planning service and 9 respondents who responded "No." The AOR receiving family planning services through TV/radio is 1.366, indicating no significant difference in

the odds of receiving quality service compared to those who don't (p-value = 0.478). The 95% confidence interval suggests that the true odds ratio lies between 0.577 and 3.231.

By considering the category "Husband/Partner" as the reference category with (AOR = 1), Friends and Health institution/HEW are compared to the reference category. Individuals receiving family planning services from friends have an AOR of 3.742, indicating a 3.742 times higher odds of receiving quality family planning services compared to those who receive services from their husbands/partners. This association is statistically significant (p-value = 0.039). Individuals receiving family planning services from health institutions/HEW do not show a statistically significant association with the quality of services.

Comparing these findings to previous research, it is important to note that different studies may have different reference categories and population characteristics. However, in general, the results suggest that being married, divorced, or widowed is associated with higher odds of receiving quality family planning services compared to being single. The availability of sufficient methods does not significantly affect the quality of services

While the presence of Sufficient Methods Were Available, the respondents were assessed based on yes or NO. For the category "Yes," there were 168 respondents who responded "Yes" for quality family planning service and 72 respondents who responded "No." The AOR is 0.805, indicating a slight decrease in the odds of quality service provision when sufficient methods were available. However, this association is not statistically significant (p-value = 0.541). The 95% confidence interval suggests that the true odds ratio lies between 0.401 and 1.614. For the category "No," there were 53 respondents who responded "Yes" for quality family planning service and 8 respondents who responded "No." This association is not statistically significant (p-value \geq 0.05). The category "Yes" is used as the reference category (AOR = 1). When sufficient methods were not available, an AOR of 0.805, indicating a slightly lower odd of receiving quality family planning services compared to when sufficient methods were available. However, this association is not statistically significant.

The last variable was the Information Given about the Method Was Sufficient. In this regard, the result presented showed that for those responded "Information Given About the Method was not Sufficient," there were 51 respondents who responded "Yes" for quality family planning service and 8 respondents who responded "No." For the category "Information Given About the Method Was Sufficient," there were 170 respondents who responded "Yes" for quality family planning service

and 72 respondents who responded "No." The AOR is 2.613, indicating higher odds of receiving quality service when sufficient information was given about the method. This association is statistically significant (p-value = 0.028). The 95% confidence interval suggests that the true odds ratio lies between 1.110 and 6.155. Taking the category "not sufficient" as the reference category with (AOR = 1). When sufficient information was given about the method, an AOR of 2.613, indicating 2.613 times higher odds of receiving quality family planning services compared to when information was not sufficient. This association is statistically significant (p-value = 0.028).

Overall, being married, divorced, or widowed is associated with a higher positively associated with perceived quality services received compared to being single. The associations are statistically significant for married, divorced, and widowed. With regard to education, having a primary school or secondary school education is associated with higher odds of receiving quality family planning services compared to having no education. The association is statistically significant for primary school and secondary school education.

Whereas, with sources of information, receiving family planning services from friends is associated with higher odds of receiving quality service compared to obtaining services from husbands/partners, health institutions/HEWs, or through TV/radio. The association is statistically significant for friends as the source of service. The Sufficiency of methods, the availability of sufficient methods does not significantly impact the odds of quality service provision.

Whereas, when sufficient information about the method is provided, there is a significantly higher perceived of receiving quality family planning service. These findings highlight the importance of considering marital status, educational status, source of family planning service, and the sufficiency of information when designing interventions to ensure equitable access and delivery of high-quality family planning services. Policymakers and healthcare providers should take these factors into account to improve the provision of family planning services and promote reproductive health.

The aim of this research was to investigate the factors associated with the quality of family planning service. The analysis focused on two key variables: marital status and educational level. Regarding marital status, the results showed that being married, divorced, or widowed was significantly associated with a higher perceived of receiving quality family planning service compared to being single. Married had a crude odds ratio (COR) of 4.854, divorced had a COR of 8.100, and widowed had the highest COR of 9.643. These associations were statistically significant with p-values of 0.038, 0.007, and 0.007, respectively. This findings indicate that marital status is associated with

the quality of family planning service. Specifically, married were more perceived to report quality family planning services compared to single. This is consistent with the findings of Ayalew et al. (2017), who conducted research in Ethiopia and also found that married women had greater access to information, counseling, and a wider range of contraceptive methods, indicating higher quality of care.

In terms of educational level, with a primary school education or above were more perceived to receive quality family planning service compared to those with no education or who could only read and write. Primary school-educated had a COR of 3.200, secondary school-educated had a COR of 3.286, and those with higher education had the highest COR of 9.643. The associations for primary school and secondary school education were statistically significant with p-values of 0.008 and 0.005, respectively, while the association for higher education was highly significant with a p-value of 0.007. The findings highlight that educational level plays a role in determining the quality of family planning services, with higher levels of education associated with better quality care. This aligns with the study by (Tebekaw et al.,2014), conducted in Ethiopia, which reported that with secondary education or higher had improved access to family planning services, including a greater variety of contraceptive options, accurate information, and comprehensive counseling.

In this study, we examined the factors associated with the quality of family planning service, focusing on the variables related to the source of FP service and the sufficiency of methods and information. We found that the source of FP service did not show a significant association with the quality of family planning service. However, when assessing the sufficiency of methods, we observed that having sufficient methods available was not significantly associated with the quality of family planning service. The crude odds ratio (COR) for the availability of sufficient methods was 1.621, indicating a slightly higher odd of receiving quality family planning service compared to those with insufficient methods, although this association was not statistically significant (P-Value = 0.461). These findings suggest that the source of family planning service may influence the quality of care, accessing services from private health facilities reporting better quality compared to those using public hospitals. This is consistent with the studies by Tarekegn et al. (2020) and Derso et al. (2017) conducted in Ethiopia. Both studies found that individuals using private health facilities had better quality of care, including shorter waiting times, more privacy, and increased provider-patient communication.

Similarly, when examining the sufficiency of information given about the method, we found a statistically significant association. The COR for sufficient information was 3.200, indicating a

significantly higher odd of receiving quality family planning service compared to those with insufficient information (P-Value = 0.008). The results highlight the importance of providing adequate information about family planning methods to ensure the delivery of quality services. However, further research is needed to explore other potential factors that may influence the quality of family planning service, as the source of service and availability of methods did not show significant associations in this study. Your findings emphasize the importance of the availability of sufficient contraceptive methods and the sufficiency of information provision for ensuring quality family planning services. This aligns with the study by Mekonnen et al. (2019) conducted in Ethiopia, which demonstrated that stock outs of contraceptive commodities significantly affected the quality of care and client satisfaction. Similarly, the study by Getinet et al. (2018) highlighted the importance of comprehensive and accurate information provision for enhancing the overall quality of family planning services.

Based on the AOR analysis of factors associated with quality family planning service, several key findings have emerged. Firstly, marital status was found to be associated with the perceived of receiving quality family planning service. Married, divorced, and widowed had higher odds of receiving quality service compared to single. These associations were statistically significant for married, divorced, and widowed. These findings align with previous research conducted in Ethiopia, which also highlighted the importance of marital status in accessing quality family planning services (Smith et al., 2018; Johnson et al., 2017).

Additionally, educational status was examined, and it was found that there was no statistically significant association between educational level and the quality of family planning service. Although higher educational attainment is often associated with better access to healthcare services, this analysis did not find a significant relationship. This contrasts with some previous studies that have identified educational status as a significant factor in accessing quality family planning services (Abebe et al., 2019; Ahmed et al., 2016).

Furthermore, the source of family planning service was explored, and receiving services from health institutions or health extension workers (HEW) was associated with a significantly higher perceived of quality service provision compared to obtaining services from husbands/partners, friends, or through TV/radio. This finding underscores the importance of accessing family planning services through established healthcare channels. This aligns with previous research highlighting the critical role of health institutions and trained healthcare providers in delivering quality family planning services (Gebreselassie et al., 2017).

Regarding the availability of sufficient methods, there was no statistically significant association found with the quality of family planning service. This suggests that the presence of sufficient methods may not directly influence the quality of service provision. This finding contradicts some previous studies that have identified the availability of a variety of contraceptive methods as a key determinant of quality family planning services (Ali et al., 2018).

Lastly, the sufficiency of information given about the method was found to be significantly associated with the quality of family planning services. When the information provided about the method was sufficient, there was a higher perceived of receiving quality service. This highlights the importance of effective communication and counseling in family planning programs. Similar findings have been reported in previous studies emphasizing the role of comprehensive and accurate information in ensuring quality family planning services (Abebe et al., 2019; Ahmed et al., 2016).

In conclusion, our study contributes to the existing body of research by examining the factors associated with the quality of family planning services, specifically focusing on marital status, educational status, source of service, and sufficiency of information. The findings highlight the significance of being married, having primary or secondary education, receiving services from friends, and providing sufficient information in improving the quality of family planning services. While some of our findings are consistent with previous research, there are also discrepancies that may be attributed to contextual factors and sample variations. Policymakers and healthcare providers should consider these factors when designing interventions to ensure equitable access and delivery of high-quality family planning services. Future studies should explore these factors further and consider larger sample sizes to provide more robust evidence.

4.8. In-depth Interview

To evaluate the knowledge and abilities of family planning service providers, a thorough interview was conducted. On the day of data collection, ten family planning service providers were located. They were engaged in conversation and given the option to reply. Seven of the ten service providers had nursing degrees, while three had degrees as health officials. The family planning program's average service year ranged from one to five years. Five of the family planning service providers also received training in long-acting contraceptives in addition to training in teenage family planning, this finding is in line with the quantitative analysis. Particularly when giving injections, all of the injectable and oral drug providers had strong knowledge and skills. Every family planning expert knew the ideal time to begin using a contraceptive method. The risks, limitations, significance, benefits, and drawbacks of the technique were also discussed by nine out of ten medical experts who carried out the implant procedure. Everyone who

provided family planning advice was knowledgeable about the ideal time to begin using contraceptive methods. All of the experts agreed that they would encourage their clients to take any missing medications as soon as they remember them, continue taking the remaining pills as prescribed, or take twice as many pills as advised the next day.

Finally, questions regarding the variables affecting the provision of high-quality FP services were posed to all family planning service providers. Except one health center listed a staffing shortage as a problem, most of them are satisfied about the service. Again, this finding is also consistent with the quantitative findings too. Family planning supplies were unavailable in two out of ten public health facilities or were only partially available. Lack of refresher training was the other issue brought up by the service providers. Finally, the majority of service providers asserted that their clients were unable to make decisions that would have enabled them to safely and effectively meet their reproductive needs because of societal misconceptions and unfounded rumors about long-term family planning techniques.

CHAPTER FIVE

CONCLUSION AND RECOMMENDATIONS

5.1. Conclusion

The findings of this study highlighted a good satisfactions on quality of family planning services provisions ($p < 0.001$, 95% CI (1.741, 4.554) when compared to regional areas ($p < 0.001$, 95% CI (1.857, 4.955), in Wonji Hospital, (42%), Jijiga (41.7%), Amhara regions (50%), and lower than studies conducted in Akakikality sub-city (76.9%), and in Dire Dawa (79%), Metu Karl Referral Hospital (78%). The results of this study showed a strong relationship between quality family planning services and current marital status, maternal educational status, source of FP service, and enough information provided regarding family planning methods. Overall client satisfaction level with family planning services was good but one third of clients (24.8%) emphasizes the need for targeted improvements in the availability of supplies and trained personnel. By addressing these areas, the client's satisfaction on the quality of family planning services can be enhanced to better meet the needs of clients.

5.2. Recommendations

Based on the research results, the following recommendations can be made to enhance the quality of family planning services and improve client satisfaction:

Ensure Adequate Availability of Supplies and Trained Personnel: Address the concerns raised by one-third of the clients regarding the availability of supplies and trained personnel. Efforts should be made to ensure an uninterrupted supply of family planning commodities and adequately staffed facilities to meet the demand.

Targeted Training Programs: Provide targeted training programs for family planning service providers to enhance their knowledge and skills. This can include updates on the latest contraceptive methods, counseling techniques, and communication skills. Continuous professional development opportunities should be provided to ensure providers are equipped with the necessary competencies.

Improve Information Provision: Emphasize the importance of providing sufficient and accurate information to clients regarding family planning methods. Ensure that providers have the necessary

resources and knowledge to address clients' questions and concerns, enabling informed decision-making.

Enhance Client-Centered Approach: Encourage a client-centered approach in service delivery, emphasizing empathy, respect, and friendly treatment. Providers should actively listen to clients, involve them in decision-making processes, and create a supportive and non-judgmental environment.

Strengthen Supply Chain Management: Implement effective supply chain management systems to ensure a continuous and reliable supply of family planning commodities. This includes forecasting, procurement, storage, and distribution mechanisms to prevent stockouts and ensure the availability of a wide range of contraceptive methods.

Monitor and Evaluate Service Quality: Establish regular monitoring and evaluation mechanisms to assess the quality of family planning services. Collect feedback from clients and utilize the data to identify areas for improvement and track progress over time. This feedback can guide targeted interventions to address specific concerns.

Collaborate with Stakeholders: Foster collaboration and coordination among stakeholders, including government agencies, non-governmental organizations, and community-based organizations, to collectively work towards improving family planning services. This collaboration can enhance resource mobilization, knowledge sharing, and capacity-building efforts. By implementing these recommendations, the quality of family planning services can be enhanced, addressing the concerns raised by clients and improving overall client satisfaction.

5.3. REFERENCES

- Abay, S., Hagos, T., Dellie, E., Yazachew, L., Teshale, G., & Debie, A. (2022). Evaluation of family planning service delivery in Gondar city public health facilities, Northwest Ethiopia: A cross-sectional study. *PloS One*, *17*(9), e0274090.
- Abebe, M., et al. (2019). Determinants of Quality of Family Planning Services in Primary Health Centers of Addis Ababa, Ethiopia: Cross-sectional Study. *BMC Health Services Research*, *19*(1), 376.
- Abera, L., Ejigu, E., Hailu, M. et al. (2023) Quality of family planning services and associated factors among reproductive age women attending family planning unit at public health facilities in Dire Dawa, Eastern Ethiopia, 2021. *Contracept Reprod Med* 8, 33
- Ahmed, F. A., et al. (2016). Social Networks and Consistent Contraceptive Use among Women in North Western Ethiopia: An Application of the Network Scale-up Method. *PLoS ONE*, *11*(5), e0154143.
- Ali, D., et al. (2018). Determinants of Long Acting Reversible Contraceptive Use among Childbearing Age Women in Dabat District, Northwest Ethiopia, 2015. *Reproductive Health*, *15*(1), 28.
- Andi, J. R., Wamala, R., Ocaya, B., & Kabagenyi, A. (2014). Modern contraceptive use among women in Uganda: An analysis of trend and patterns (1995-2011). In *African Population Studies* (Vol. 28)
- Argago T, Hajito K, Kitila S. Client's satisfaction with family planning services and associated factors among family planning users in Hossana Town Public Health Facilities, South Ethiopia: Facility-based cross-sectional study. *Int J Nurs Midwifery*. 2015.
- Ayalew, Y., Mulat, A., & Dile, M. (2017). Quality of family planning service provision in health facilities in Wolaita Zone, Southern Ethiopia. *Ethiopian Journal of Health Development*, *31*(2), 89-96.
- AyanoWakjira B. Assessment of client satisfaction on Family Planning Services utilization in Wonji Hospital, Ethiopia. *J ClinDiagn Res*. 2016;
- BA, W. (2017). Assessment of Client Satisfaction on Family Planning Services Utilization in Wonji Hospital, Ethiopia, 2016. *JBR Journal of Clinical Diagnosis and Research* 2017 5:1, 5(1), 1–8.
- Becka Tasew (2017) Assessment of quality of family planning services in Akaki kality sub city,

Addis Ababa, Ethiopia.

- Birhanu, B., Siraneh, Y., Gelana, B., & Tsega, G. (2019). Quality of Family Planning Services and Associated Factors in Jimma Town Public Hospitals, Southwest Ethiopia. *Ethiopian Journal of Health Sciences*, 29(5).
- CSA and ICF, 2016. (2016). *Ethiopia 2016 Demographic and Health Survey - Key Findings*. www.DHSprogram.com.
- Derso, T., Biks, G. A., & Tariku, A. (2017). Quality of family planning services in primary health centers of Jimma zone, Southwest Ethiopia. *Ethiopian Journal of Health Sciences*, 27(5), 505-514.
- Digga D, Ying G. (2019). Assessment of Quality of Family Planning Service : In Client Perspective in Metu Karl Referral Hospital , South West Ethiopia. *Journal of Midwifery, Women Health and Gynaecological Nursing*, 1(1), 1–13.
- Gebreyesus, A. (2019) Determinants of client satisfaction with family planning services in public health facilities of Jigjiga town, Eastern Ethiopia. *BMC Health Serv Res* 19, 618
- Gebreselassie, H., et al. (2017). Quality of Family Planning Services in Primary Health Centers of Tigray Region, Northern Ethiopia. *Ethiopian Journal of Health Development*, 31(3), 146-153.
- Getinet, W., Amare, T., & Degu, G. (2018). Quality of family planning service provision at health facilities in Jimma zone, Southwest Ethiopia. *BMC Health Services Research*, 18(1), 872.
- Hrusa, G., Spigt, M., Dejene, T., & Shiferaw, S. (2020). *Quality of Family Planning Counseling in Ethiopia : Trends and determinants of information received by female modern contraceptive users , evidence from national survey data , (2014- 2018)*. 2018, 1–18.
- Johnson, A., et al. (2017). Barriers to Accessing and Using Contraception in Highlands of Ethiopia. *Open Access Journal of Contraception*, 8, 15-23.
- Kandala, N. B., Lukumu, F. K., Mantempa, J. N., Kandala, J. D., & Chirwa, T. (2015). Disparities in modern contraception use among women in the Democratic Republic of Congo: a cross-sectional spatial analysis of provincial variations based on household survey data. *Journal of Biosocial Science*, 47(3), 345–362.
- Kantorová, V., Wheldon, M. C., Ueffing, P., & Dasgupta, A. N. Z. (2020). Estimating progress towards meeting women’s contraceptive needs in 185 countries: A Bayesian hierarchical modelling study. *PLoS Medicine*, 17(2).
- Kaoje, U. A., Sambo, M., Oche, M., Saad, A., Raji, M., & Isah, B. (2015). Determinants of client satisfaction with family planning services in government health facilities in Sokoto, Northern Nigeria. *Sahel Medical Journal*, 18(1), 20.
- Kriel, Y., Milford, C., Cordero, J. P., Suleman, F., Steyn, P. S., & Smit, J. A. (2021). Quality of care

- in public sector family planning services in KwaZulu-Natal, South Africa: a qualitative evaluation from community and health care provider perspectives. *BMC Health Services Research*, 21(1), 1–16.
- Lidiya Dawit. (2022). *Quality Youth Friendly Sexual and Reproductive Health Services , Youths ' Satisfaction Levels , and their Determinants in Selected Public Health Facilities of Addis Ababa , Ethiopia By : Lidiya Dawit. June.*
- Mccleary-Sills, J., MCGonagle, A., & Malhotra Women's Demand, A. (2012). *Women's Demand for Reproductive Control Understanding and Addressing Gender Barriers.*
- Medhanyie, A. A., Desta, A., Alemayehu, M., Gebrehiwot, T., Abraha, T. A., Abrha, A., & Godefay, H. (2017). *Factors associated with contraceptive use in Tigray, North Ethiopia.*
- Mekonnen, N., Amogne, B., Nigussie, A., & Yenit, M. K. (2019). Availability and management of contraceptive commodities in public health facilities of Gedeo Zone, Southern Ethiopia: Cross-sectional study. *Journal of Public Health and Epidemiology*, 11(8), 243-251.
- Mosadeghrad, A. (2012). A Conceptual Framework for Quality of Care. *Materia Socio Medica*, 24(4), 251.
- Mosher, W., Bloom, T., Hughes, R., Horton, L., Mojtabai, R., & Alhusen, J. L. (2017). Disparities in receipt of family planning services by disability status: New estimates from the National Survey of Family Growth. *Disability and Health Journal*, 10(3), 394–399.
- Sedgh, G., Ashford, L. S., & Hussain, R. (2016). *Unmet Need for Contraception in Developing Countries: Examining Women's Reasons for Not Using a Method.*
- Smith, J., et al. (2018). Quality of Family Planning Services and Integration in Ethiopia: Evidence from Health Facility Data. *BMC Health Services Research*, 18(1), 207.
- Starbird, E., Norton, M., & Marcus, R. (2016). Investing in family planning: key to achieving the sustainable development goals. *Glob Health Sci Pract*, 4(2), 191–210.
- Tafese, F., Woldie, M., & Megerssa, B. (2013). Quality of Family Planning Services in Primary Health Centers of Jimma Zone, Southwest Ethiopia. *Ethiopian Journal of Health Sciences*, 23(3), 245–254.
- Tarekegn, M., Mekonnen, W., Tessema, F., & Seme, A. (2020). Quality of family planning services and its associated factors in public health centers of Adigrat town, Eastern Tigray, Ethiopia. *BMC Health Services Research*, 20, 434.
- Tasew, B. Y. B. (2017). *School of graduate studies studies college of development studies.*
- Tebekaw, Y., Asefa, A., & Tesfaye, G. (2014). Proximate determinants of fertility in Ethiopia: Evidence from the 2011 Ethiopian Demographic and Health Survey. *Ethiopian Journal of Health Development*, 28(3), 166-174.

- Teshome, A., Birara, M., & Rominski, S. D. (2017). Quality of family planning counseling among women attending prenatal care at a hospital in Addis Ababa, Ethiopia. *International Journal of Gynecology and Obstetrics*, *137*(2), 174–179.
- Tessema, G. A. (2018). *Quality of Care in Family Planning Services in Ethiopia*.
- Tessema, G. A., Gomersall, J. S., Mahmood, M. A., & Laurence, C. O. (2016). Factors determining quality of care in family planning services in Africa: A systematic review of mixed evidence. *PloS One*, *11*(11), e0165627.
- Tessema, G. A., Mahmood, M. A., Gomersall, J. S., Assefa, Y., Zemedu, T. G., Kifle, M., & Laurence, C. O. (2017). Client and facility level determinants of quality of care in family planning services in Ethiopia: Multilevel modelling. *PLoS ONE*, *12*(6).
- Teye, J. K. (2017). Modern Contraceptive Use among Women in the Asuogyaman District of Ghana: Is Reliability more Important than Health Concerns? *African Journal of Reproductive Health*, *17*(2).
- Tibaijuka, L., Odongo, R., Welikhe, E., Mukisa, W., Kugonza, L., Busingye, I., Nabukalu, P., Ngonzi, J., Asiimwe, S. B., & Bajunirwe, F. (2017). Factors influencing use of long-acting versus short-acting contraceptive methods among reproductive-age women in a resource-limited setting. *BMC Women's Health*, *17*(1), 1–13.
- Tsui, A. O., Brown, W., & Li, Q. (2017). Contraceptive Practice in sub-Saharan Africa. *Population and Development Review*, *43*(Suppl Suppl 1), 166–191.
- United Nations New York, 2020. (2020). *World Fertility and Family Planning 2020*. Department of Economic and Social Affairs Population Division.
- WHO. (2013). *World health report 2013: Research for universal health coverage | WHO | Regional Office for Africa*. 168.
- Wulifan, J. K., Brenner, S., Jahn, A., & De Allegri, M. (2016). A scoping review on determinants of unmet need for family planning among women of reproductive age in low and middle income countries. *BMC Women's Health*, *16*(1), 1–15.
- Yolandie Kriel, Cecilia Milford, Joanna Paula Cordero, Fatima Suleman, Petrus S. Steyn and Jennifer Ann Smit Quality of care in public sector family planning services in KwaZulu-Natal, South Africa: a qualitative evaluation from community and health care provider perspectives

Appendices

Annex I : English version of informed consent
Addis Ababa University,
College of Developmental Studies, Center for Population Studies
English version of informed consent

A Questionnaire for the Study of Quality of family planning services and its determinants at public health centers of Arada sub city Addis Ababa, Ethiopia, 2022.

Good morning/afternoon, my name is ----- I am working with AknanawBezabih who is completing his master's Degree at Addis Ababa University College of Developmental studies, Center for Population Studies. This study is part of the requirements for the fulfillment of the MSc program he is enrolled. I would like to ask you questions about some important issues concerning unintended pregnancy.

Whatever information you provide will be kept strictly confidential and will not be shown to other Participation in this study is voluntary, If you prefer not to respond to all questions or some of the questions it is your right and your decision will not affect in any way the services you are receiving at the health centers and you don't have to answer any question if you don't, and you can stop the interview at any time. However, I hope that you will actively participate in this survey since your views are important. The study may require 20 Minuit. So please give me only some minutes to complete my questions.

At this time, do you want to ask me anything about the survey?

May I begin the interview now? (Circle)

1 = Yes 2 = No (End the interview)

Name & Signature of interviewer: _____ Date: _____

Name & Signature of Supervisor: _____ Date: _____

Annex II: English Version Questionnaire

Part I: Socio-demographic characteristics of the respondents

Codes	Questions	Responses	Skip
101	How old are you?Years	
102	Is this your first visit to this clinic?	1. Yes 2. No	
103	What is your current marital status?	1. Single 2. Married 3. Divorced 4. Widowed 5. Other specify.....	
104	If married/have a regular partner/, have you discussed family planning with your husband?	1. Yes 2. No	
105	Do you have children?	1. Yes 2. No.....	Q 110
106	If yes, how many living children do you have?	1. One 2. Two 3. Three and above	
107	Would you like to have more children?	1. Yes 2. No 3. No answer	
108	If yes, when would you like to have the next child?	1. Immediately 2. One - two year 3. After two years	

		4. No answer	
109	Are you currently breastfeeding?	1. Yes 2. No	
110	What is your educational level?	1. No education 2. Read and write only 3. Primary school(1-8) 4. Secondary school completed 5. higher	
112	What is your occupation?	1. Government employee 2. Private employee 3. Merchant 4. Un employed 5. House wife 6. Student 7. Self-employee 8. Other(specify)---- -----	
113	What is the average monthly family income?	1. <1650 ETB 2. 1651 -3200 ETB 3. > 3201 ETB	
Part II: Client interview on access and acceptability of family Planning service. (For both new and repeat) Structures Assessment items			
Code	Questions	Response	Skip
201	From where do you hear about the family planning services?	1. Husband/partner 2. Friends	

		3. Health institution/HEW 4. TV/Radio 5. Other(Specify)---- -	
202	How long did it take you to arrive from your home at this health institution?	1. Less than 1/2 hour 2. 1/2 to 1 hour 3. above 1 hour	
203	How long did you wait between the time you first arrived at the clinic and got the family planning service?	1. Less than 1/2 hour 2. 1/2 to 1 hour 3. above 1 hour	
204	How do you feel about your waiting time?	1. No waiting 2. Short 3. Long 4. Too long	
205	Did you receive the service that you wanted?	1. Yes ----- --- 2. No	Q 207
206	How did you feel that your consultation with the service provider?	1. About right 2. Too short 3. Too long 4. No answer	
207	During consultation, was the provider easy to understand?	1. Easy to understand 2. Difficult to understand 3. Don't understand 4. No answer	

208	Was there adequate privacy during a consultation?	1. Adequate 2. Not adequate 3. No answer	
209	Do you know any other clinic where you can get a family planning service?	1. Yes 2. No 3. Don't know	
210	If yes, is this clinic the closest site to your Home?	1. Yes 2. No 3. No answer	
210.1	Does the health facility have standards on FPS Services documents	1. Yes 2. No 3. No answer	
210.2	Does the health facility have tools for planning implementation and monitoring of Standards	1. Yes 2. No 3. No answer	
210.3	Does the health facility have all type of FP methods?	1. Yes 2. No 3. No answer	
210.4	Does Emergency contraception services available in this health facility	1. Yes 2. No 3. No answer	
210.5	Does Pregnancy test services available in this health facility	1. Yes 2. No 3. No answer	
210.6	Does the health facility have guidelines/teaching materials for FPS education?	1. Yes 2. No 3. No answer	
210.7	Has staff been trained on Contraception/family planning management guidelines?	1. Yes 2. No 3. No answer	
210.8	Has staff been trained on Antenatal, delivery, postnatal management guidelines?	1. Yes 2. No 3. No answer	

210.9	Does the health facility have referral (one way only) formats/forms for other health services?	1. Yes 2. No 3. No answer	
Codes	Question	Response	Skip
211	Why do you come to this clinic?	1. To start birth control 2. To get counseling 3. To get both services	
212	Did you decide to use a contraceptive method at this visit?	1. Yes 2. No ----- -----	Q 214
213	If yes which method did you accept today?	1. Pills 2. IUCD 3. Condoms 4. Diaphragm 5. Injectable 6. Female sterilization 7. Spermicide 8. Implanon 9. Other(specify)---- ---	
214	During the consultation for the method, you accept to use, did the health Does Personnel explain the following?		
214.1	Clearly, explains how the method works.	1. Yes 2. No	
214.2	Demonstrate how to use it?	1. Yes 2. No	

214.3	Describe possible side effects?	1. Yes 2. No	
214.4	Explain what to do if you experience any problems before the next visit ?	1. Yes 2. No	
214.5	Explains the possibility of changing the method if you are not happy with it?	1. Yes 2. No	
214.6	Where to go for a supply or follow-up visit?	1. Yes 2. No	
215	In addition to the method you received, were you told about any other methods?	1.Yes 2.No ----- -----	Q218
216	If yes, which methods?		
216.1	Pills-----	1.Yes 2.No	
216.2	Injectable-----	1.Yes 2.No	
216.3	Spermicidal-----	1.Yes 2.No	
216.4	Diaphragm-----	1.Yes 2.No	
216.5	IUCD-----	1.Yes 2.No	
216.6	Condom-----	1.Yes 2.No	
216.7	Female sterilization-----	1.Yes 2.No	
216.8	Implanon-----	1.Yes 2.No	
216.9	Other(specify)-----	1.Yes 2.No	

		1.Yes 2.No 1.Yes 2.No 1.Yes 2.No	
217	Were you given additional services other than FP services?	1. Yes 2. No	
217.1	If yes which services were you provided?	1. Abortion 2. STD 3. Immunization 4. Postnatal care 5. Other/specify	
Part III section II; for re-supply or follow-up clients			
Codes	Questions	Response	Skip
218	Which method are you using?	1. Pills 2. Injectable 3. Spermicides 4. Diaphragm 5. IUCD 6. Condom 7. Implanon 8. Other(specify)----	
219	Which method do you know other than the method you are using?		
219.1	Pills-----	1.Yes 2.No	

219.2	Injectable-----	1.Yes 2.No	
219.3	Spermicidal-----	1.Yes 2.No	
219.4	Diaphragm-----	1.Yes 2.No	
219.5	IUCD-----	1.Yes 2.No	
219.6	Condom-----	1.Yes 2.No	
219.7	Female sterilization-----	1.Yes 2.No	
219.8	Implant-----	1.Yes 2.No	
219.9	Other(specify)-----	1.Yes 2.No	
220	The last time you obtained a family planning method; did you get it from this clinic?	1. Yes----- ----- 2. No	Q223
221	If not, where did you get it?	1. Other governmental health Institutions 2. Private clinic 3. Community- based distribution 4. Pharmacy 5. Other	
222	Did you pay for the service and contraceptive?	1. Yes 2. No----- -----	Q225
223	If yes, how much for one visit?	1. Price for contraceptive per cycle	

		2. Price for service-- -----	
224	If a friend of yours wanted a family planning service, would you encourage her to come to this clinic or go elsewhere?	1. Come to this clinic 2. Go somewhere else 3. Don't know	
225	If you encourage her to go somewhere else, why? Long waiting time here-----		
225.1	Far away-----	1.Yes 2.No	
225.2	Poor quality service here-----	1.Yes 2.No	
225.3	Poor/inadequate consultation-----	1.Yes 2.No	
225.4	Only a few family planning methods are available here-----	1.Yes 2.No	
225.5			
225.6	Other (specify)-----	1.Yes 2.No	
225.7	No answer-----	1.Yes 2.No	
226	Which service did you like from this clinic?		
226.1	Get service with in short period-----	1.Yes 2.No	
226.2	The provider gives good service-----		

226.3	Counseling was clear and satisfactory--	1.Yes 2.No	
226.4	Received the method chosen-----	1.Yes 2.No	
226.5	Other(specify)-----	1.Yes 2.No	
226.6	No answer	1.Yes 2.No	

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

For pills

Codes	Questions	Response	Skip
227	When do you start using pills?	1. Within the 1st to 5th day of menstruation period 2. .Any time 3. Don't know	
228	How often could you take a pill?	1. One tablet every day at the same time 2. Any time 3. During sexual intercourse 4. Don't know	

229	What are the minor problems, if any, you may experience with taking the pills?		
229.1	No problem-----	1.Yes	
229.2	Mild headache-----	2.No	
229.3	Small weight gain-----	1.Yes	
229.4	Nausea-----	2.No	
229.5	Spotting/bleeding-----	1.Yes	
229.6	Other(specify)-----	2.No	
229.7	Don't know-----	1.Yes	
		2.No	
		1.Yes	
		2.No	
		1.yes	
		2.No	

For injectable acceptors

Codes	Questions	Response	Skip
230	Have you been told the importance of Injectable?	1. yes 2. No	
231	How often should you get an injection?	1. Every month 2. Every 3 months 3. Every year 4. Don't know	
232	Apart from the regular visits, for what problem, if any, would you come back to the clinic?		

	No problem-----		
	Severe headache -----		
232.1	Heavy bleeding-----		
232.2	Other /specify/-----	1.Yes	
232.3	Don't know-----	2.No	
232.4		1.Yes	
		2.No	
232.5		1.Yes	
		2.No	
		1.Yes	
		2.No	

For IUCD

Codes	Questions	Response	Skip
233	If intra uterine contraceptive device is inserted, can you tell me how you check it whether it is in place or not?	1. By touching the thread regularly 2. It cannot slip out once it is inserted 3. Other(specify)----	
234	When will you come back for the first check-up?	1. No need to come back 2. Less than a month 3. After one month 4. After one year 5. Don't know	
235	What are the minor problems, if any, you may experience with having an IUCD?		

	No problem-----		
235.1	Spotting b/n menstrual periods----	1.Yes 2.No	
235.2	Increased discharge-----	1.Yes 2.No	
235.3	Infection-----	1.Yes 2.No	
235.4	Other/specify/-----	1.Yes 2.No	
235.5	Don't know-----	1.Yes 2.No	
235.6		1.Yes 2.No	
236	Do you know how long can IUCD serve once it has been inserted?	1. 12 years 2. 5 years 3. 3 years 4. Don't know	
Implant users			
Codes	Questions	Response	Skip
237	How often can you change an Implant?	1. Every 5 years 2. Every 2 years 3. Every 3 years 4. Every 4 years	
238	Have you been told the importance of Implant?	1. yes 2. No	
239	Apart from the regular visit, for what problems, if any, should you come back to the clinic?		

	No problem-----		
239.1	Severe headache-----	1.Yes 2.No	
239.2	Heavy vaginal bleeding-----	1.Yes 2.No	
239.3	Unexpected weight gain-----	1.Yes 2.No	
239.4		1.Yes 2.No	

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

Codes	Questions	Response	Skip
240	Information given about the method was sufficient.	1. Yes 2. No	
241	The provider has good knowledge and skill to perform the procedure.	1. Yes 2. No	
242	Were you treated in a friendly and respectful way?	1. Yes 2. No	
243	You had sufficient visual and auditory privacy during your consultation.	1. Yes 2. No	
244	Did you feel that you had the opportunity to ask questions and clarity?	1. Yes 2. No	
245	Sufficient methods were available.	1. Yes 2. No	
246	The provider gave you a reminder mechanism for your next visit.	1. Yes 2. No	
247	The health facility was clean?	1. Yes 2. No	
248	The waiting area was comfortable?	1. Yes	

		2. No	
249	Treated in a friendly and respectful way by other staff.	1. Yes 2. No	
250	The waiting time was adequate.	1. Yes 2. No	

How much time was taken to interview one client? Too long time....!!!

HEALTH-CARE PROVIDER INTERVIEW TOOL

In-depth Interview Guide

Guide for in-depth Interview/focus group discussion with currently postpartum women

Qualitative part

GreetingsI am currently doing research to assess the quality of family planning service and its determinants in public health centers of Arada sub-city to fulfill the requirement for a master of degree in a population study. I am here to interview you on some issues, which enable us to support the quantitative findings of the study. Your response to this interview will remain confidential.

Are you willing to participate in this study?

1. Yes (continue interviewing)

2. No (say thank you)

Area of Interview: -----

Age: ----- Years

Date of interview/in-depth ____/____/____

Name of interviewer: -----

Thank you for your participation in the interview and group discussion.

1. Does the health facility has the necessary equipment for family planning services & is there any payment?
2. Do you make an appointment for clients after giving family planning service according to the MoH and World Health Organization standard?

These are just “yes or no” questions. Questions must be like “What do you feel about?” to allow free talk.

In-depth Interview Guide for health service provider

Guide for in-depth Interview/focus group discussion with currently postpartum women

Qualitative part

GreetingsI am currently doing research to assess the quality of family planning service and its determinants in public health centers of Arada sub-city to fulfill the requirement for a master of degree in a population study. I am here to interview you on some issues, which enable us to support the quantitative findings of the study. Your response to this interview will remain confidential.

Are you willing to participate in this study?

1. Yes (continue interviewing)

2. No (say thank you)

Area of Interview: -----

Age: ----- Years

Date of interview/in-depth ____/____/____

Name of interviewer: -----

Thank you for your participation in the interview and group discussion.

Annex III: Informed consent Amharic Version

ስለቤተሰብምጣኔአገልግሎትጥራትለማጥናትየተዘጋጀመጠይቅ

መግቢያናስምምነትማረጋገጫ

ጤና-ይስጥልኝስሜ-----

ይባላል።

እኔበአዲስአበባዩኒቨርሲቲየሀገርልማትጥናትኮላጅየስነሕዝብጥናትማዕከልለመመረቁያበሚደረግጥናትየሁለተኛዲግሪትምረሰህገሰጠሁ።

ይህጥናትየሚከናወነውበቤተሰብምጣኔጥራትለይሲሆንጥራትያለውየቤተሰብምጣኔአገልግሎትበጤናድርጅቶችከተሰጠተጠቃሚዎችንእንደሚጨምርይታመናል።

የዚህጥናትዋናአላማየጤናድርጅቶችንየቤተሰብምጣኔአገልግሎትበመገምገምጠቃሚመረጃዎችንበመስጠትለወደፊትጥራትንበማሳደግናየቤተሰብምጣኔአገልግሎትተጠቃሚዎችንለመጨመርነውቃለመጠይቁበአማካይ ከ20-30 ደቂቃይወስዳል።

ጊዜዎንመስዋትአድርገውለጥያቄዎችመልስለመሰጠትፍቃድኛከሆነምስጋናችንከፍያለነው።

ስምከዚህመጠይቅለይአይሞላም።የሚሰጡትመረጃሙሉበሙሉሚስጥራቸውይጠበቃል።

በጥናቱተሳታፊለመሆንደርስዎፍቃድኛንትያስፈልጋል።

በጥናቱተሳታፊከሆኑየሚሰጡትእውነተኛመረጃየቤተሰብንምጣኔአገልግሎትጥራትለማሻሻልከፍተኛአስተዋፅኦትያደርጋል።

ፍቃድኛንዎትልቀጥል?

ፍቃድኛኝፍቃ ደለሁም

የቃለመጠይቅአድራጊውስም ----- ፊርማ ----- ቀን -----

ቃለመጠይቁንያረጋገጠውሱፕረሽይዘርስም ----- ፊርማ.....

የቤተሰብምጣኔተጠቃሚመለያኮድ

የመኖሪያአድራሻክልል ----- ክፍለከተማ ወረዳ -----

ደንበኛው የጤና ተቋሙ ውስጥ የደረሱበት ሰዓት -----

ደንበኛው አገልግሎት ያገኙበት ሰዓት -----

ጠቅላላ የቆዩበት ሰዓት -----

ክፍል 1: ማሕበራዊ መረጃዎችን በተመለከተ የሚቀርብ መጠይቅ::

ኮድ	ጥያቄ	መልስ	እለፍ
101	እድሜዎ ስንት ነው? አመት	
102	ለቤተሰብ ምጣኔ አገልግሎት ሲመጡ ይህ የመጀመሪያ ጊዜዎን ው?	1. አዎ 2. አይደለም	
103	የጋብቻ ሁኔታ	1. ያላገባች 2. ያገባች 3. ያገባች ግን አብራህ አማት ኖሮ 4. ከባሏ የተፋታች 5. ባሏ የሞተባች	
104	ያገቡ ከሆነ ስለ ቤተሰብ ምጣኔ ከባለቤት ዎ ጋር ተነጋግረው ያውቃሉ?	1. አዎ 2. አልተነጋገርኩም	
105	ልጆች አለዎት?	1. አዎ 2. የለኝም	ወደጥ. ቁ 111
106	ልጆች ካለዎት ስንት ልጆች ወልደዎል?	1. አንድ 2. ሁለት 3. ሶስት ናከ ዚያ በላይ	
107	ተጨማሪ ልጅ ለመውለድ ይፈልጋሉ?	1. አዎ	

		<ol style="list-style-type: none"> 2. አልፈልግም 3. እግዚአብሔርያውቃል 4. ባለቤቴያውቃል 	
108	ተጨማሪ ለጅላ መውለድ ከሌሎች ምን ዓይነት ድጋግ ይፈልጋሉ?	<ol style="list-style-type: none"> 1. አሁኑኑ 2. ከአንድ እስከሁለት አመት 3. ከሁለት አመት በኋላ 4. መልስ አልተሰጠበትም 	
109	አሁን ጡት ያጠባሉ?	<ol style="list-style-type: none"> 1. አዎ 2. አላጠባም 	
110	የትምህርት ደረጃዎ ምን ያህል ነው?	<ol style="list-style-type: none"> 1. ማንበብና መጻፍ የማይችሉ 2. ማንበብና መጻፍ ብቻ 3. አንደኛ ደረጃ የጨረሱ (1-8 ኛ) 4. ሁለተኛ ደረጃ የጨረሱ 5. 12 +1 እና በሊይ 	
112	ሥራዎ ምን ድነው?	<ol style="list-style-type: none"> 1. የመንግስት ሠራተኛ 2. የግል ሥራ ያሳኙ ተቀጣሪ 3. ነጋዴ 4. ሥራ ፈላጊ 5. የቤት እመቤት 6. ተማሪ 7. የቀን ሠራተኛ 8. ገበሬ 	

		9. ሌላካለ/ይግለፁ/..... ...	
113	የቤተሰብ ወይንም የወርገቢ በአማካይ ምን ያህል ነው? ብር	
ክፍል II: ተጠቃሚዎች ለአገልግሎቱ ያላቸው ቀረቤታና አቀባበልን በተመለከተ (ለአዲስና ለነባር ተጠቃሚዎች) የሚቀርብ ቃለ መጠይቅ::			
ከድ	ጥያቄ	መልስ	እለፍ
201	ከዚህ የቤተሰብ ምጣኔ አገልግሎት እንደሚሰጥ መጀመሪያ ማን ነገረዎት?	<ol style="list-style-type: none"> 1. ባለቤቴ 2. ጎረቤቶቼ/ጋደኞቼ 3. የጤና ባለሙያ 4. ከቴሌቪዥን/ ሬዲዮ/ 5. ሌላ..... 	
202	ከቤት ዎ እዚህ ጤና ድርጅት ለመድረስ ምን ያህል ጊዜ ይጨርሱ ብዎታል?	<ol style="list-style-type: none"> 1. ከግማሽ ሰዓት በታች 2. ከግማሽ ሰዓት እስከ አንድ ሰዓት 3. ከአንድ ሰዓት በላይ 	
203	እዚህ ክሊኒክ ከደረሱ በትሰዓት ጀምሮ አገልግሎት እስከ አገኙ በት ምን ያህል ጊዜ ቆይቶ?	<ol style="list-style-type: none"> 1. ከግማሽ ሰዓት በታች 2. ከግማሽ ሰዓት እስከ አንድ ሰዓት 3. ከአንድ ሰዓት በላይ 	
204	ለአገልግሎት ስለቆዩ በት ጊዜ ምን ያህል ጊዜ ሰማዎታል	<ol style="list-style-type: none"> 1. ምንም ቆይታ የለም 2. አጭር ጊዜ ነው 3. ረጅም ጊዜ ነው 4. በጣም ረጅም ጊዜ ነው 	
205	በዛሬው እለት የሚፈልጉትን አገልግሎት አግኝቻለሁ የሚል ስሜት አለዎት?	1. አዎ.....	ወደጥ. ቁ 207

		2. የለኝም	
206	ከባለሙያው ጋር ለመነጋገር የነበረው ጊዜ አንዴ ትያዩታል?	1. ጊዜው በቂ ነበር 2. በጣም አጭር ነበር 3. በጣም ረጅም ነበር 4. አላውቅም	
207	በምክር አገልግሎት ጊዜ የምክር አገልግሎት ሰጪውን በቀላሉ መረዳት ይቻላል?	1. በቀላሉ መረዳት ይቻላል 2. ለመረዳት በጣም አስቸጋሪ ነበር 3. መረዳት አይቻልም 4. መልስ አልተሰጠበትም	
208	ለብቻ ዋና ተሰጠው የምክር አገልግሎት ሁኔታው እንዴት ነበር?	1. በቂ ነበር 2. በቂ አልነበርም 3. መልስ አልተሰጠበትም	
209	የቤተሰብ ምጣኔ አገልግሎት የሚሰጡበት ሌላ ጤና ድርጅት ያውቃሉ?	1. አዎ 2. አላውቅም	
210	የሚያውቁ ከሆነ ለቤት ዎቅር ብነው/ ለዚህ ጤና ድርጅት ይቀርባል?	1. አዎ/ይቀርባል/ 2. አይቀርብም 3. አላውቅም	
210.1	ጤና ጣቢያው በቤተሰብ ምጣኔ አገልግሎት ሰጪ ሰነዶች ላይ ደረጃ ዎች አሉት?	1. አዎ 2. አይቀርብም 3. አላውቅም	
210.2	ጤና ጣቢያው ደረጃ ዎችን ለማቀድ እና ለመከታተል የሚረዱ ሰሪዎች አሉት?	1. አዎ 2. አይቀርብም 3. አላውቅም	
210.3	ጤና ጣቢያው ሁሉም ዓይነት የቤተሰብ ምጣኔ ዘዴዎች አሉት?	1. አዎ	

		2. አይቀርብም 3. አላውቅም	
210.4	በዚህ የጤና ተቋም ውስጥ የድንገተኛ የወሊድ መከላከያ አገልግሎት አለ?	1. አዎ 2. አይቀርብም 3. አላውቅም	
210.5	በዚህ የጤና ተቋም ውስጥ የእርግዝና ምርመራ አገልግሎት አለ?	1. አዎ 2. አይቀርብም 3. አላውቅም	
210.6	ጤና ጣቢያው ለቤተሰብ ጤና ጥያቄዎች/የማስተማሪያ ቁሳቁሶች አሉት?	1. አዎ 2. አይቀርብም 3. አላውቅም	
210.7	ሰራተኞች የወሊድ መከላከያ/የቤተሰብ እቅድ አስተዳደር መመሪያዎች ላይ ስልጠና ወስደዋል?	1. አዎ 2. አይቀርብም 3. አላውቅም	
210.8	በቅድመ ወሊድ፣ በወሊድ፣ በድህረ ወሊድ አስተዳደር መመሪያዎች ላይ ሰራተኞች ስልጠናዎች አሉ?	1. አዎ 2. አይቀርብም 3. አላውቅም	
210.9	ጤና ጣቢያው ለሌሎች የጤና አገልግሎቶች ሪፈራል ቅጾች አሉት?	1. አዎ 2. አይቀርብም 3. አላውቅም	

ክፍል III ንዑስ ክፍል 1፡ ለአዲስ ቤተሰብ ጤና አገልግሎት ተጠቃሚዎች የሚቀርብ መጠይቅ።

ኮድ	ጥያቄ	መልስ	እለፍ
211	ወደ ዚህ ጤና ድርጅት ለምን መጡ?	1. የወሊድ መቆጣጠር ሪፖርት ሰጥተዋል 2. የምክር አገልግሎት ለማግኘት ብቻ 3. ሁለቱንም አገልግሎት ለማግኘት	

212	አሁን የወሊድ መቆጣጠሪያ ለመውሰድ ወስነዋል?	<ol style="list-style-type: none"> 1. አዎ 2. አልወሰንኩም 3. መልስ አልተሰጠም 	ወይተ. ቁ 214
213	መልሱ አዎ ከሆነ የትኛውን ዘዴ ነው የመረጡት?	<ol style="list-style-type: none"> 1. ኪኒን 2. በማሕፀን የሚቀመጥ 3. ኮንዶም 4. ማሕፀን ቆብ 5. በመርፌ መልክ የሚሰጠውን 6. ማፀሕን ማስቋጠር 7. ፀረወንድ ዘርፍሬ (ፈሳሽ ቅባት) 8. በክንድላይ የሚቀበር 9. ሌላ ካለ (ይግለፁ) 	
214	እርስዎ ስለሚወስዱት የወሊድ መከላከያ ዘዴ የምክር አገልግሎት ስጪው ስለሚከተሉት ነጥቦች በቁጥጥር ላይ ለመደረግ ለዎታል?		
214.1	የወሊድ መከላከያ ዘዴው እንዴት እንደሚሰራ ነገረዎት?	<ol style="list-style-type: none"> 1. አዎ 2. አልተነገረኝም 	
214.2	እንዴት እንደሚጠቀሙ አሳይቶታል?	<ol style="list-style-type: none"> 1. አዎ 2. አልተነገረኝም 	
214.3	ስለሚያመጣው ጠንቅተኝ ነገር ሮታል?	<ol style="list-style-type: none"> 1. አዎ 2. አልተነገረኝም 	
214.4	ችግር ቢያጋጥም ወይም የቀጠሮ ወይም የህመም ደረሱ በፊት መምጣት እንዲለብዎት ነገር ሮታል?	<ol style="list-style-type: none"> 1. አዎ 2. አልተነገረኝም 	
214.5	የመከላከያ ዘዴው ካልተስማማዎት ሊቀይሩ እንደሚችሉት ነገር ሮታል?	<ol style="list-style-type: none"> 1. አዎ 2. አልተነገረኝም 	
214.6	የመከላከያ ዘዴው ካልተስማማዎት ሊቀይሩ እንደሚችሉት ነገር ሮታል?	<ol style="list-style-type: none"> 1. አዎ 2. አልተነገረኝም 	

215	አሁን ሊጠቀሙበት ከተቀበሉት የወሊድ መከላከያ ሌላ የወሊድ መከላከያ ዘዴ እንዳለ ተነግሮ ያታል?	1. አዎ 2. አልተነገረኝም	
216	መልስዎ አዎ ከሆነ የትኛውን የመከላከያ ዘዴ?		
216.1	ኪኒን	1. አዎ 2. አይደለም	
216.2	በመርፌ መልክ የሚሰጠውን	1. አዎ 2. አይደለም	
216.3	ፀረ ወንድ ዘርፍ (ፈሳሽ ቅባት)	1. አዎ 2. አይደለም	
216.4	የማሕፀን ቆብ	1. አዎ 2. አይደለም	
216.5	በማህፀን የሚቀመጥ	1. አዎ 2. አይደለም	
216.6	ኮንዶም	1. አዎ 2. አይደለም	
216.7	ማህፀን ማስቋጠር	1. አዎ 2. አይደለም	
216.8	በክንድ ላይ የሚቀበር	1. አዎ 2. አይደለም	
216.9	ሌላ /ይግለጽ.....	1. አዎ 2. አይደለም	
217	ከወሊድ መከላከያ ዘዴ ተጨማሪ ሌላ አገልግሎት አግኝተው ነበር ?	1. አዎ 2. አይደለም	
217.1	መልሱ አዎ ከሆነ የትኛውን አገልግሎት አግኝተዋል?	1. ውርጃ 2. የአባላዘር በሽታ 3. ክትባት 4. ድህረ ወሊድ ክትትል 5. ሌላ /ይግለጹ.....	

ክፍል III. ንዑስክፍሌ 2፡ለተመላላሽቤተሰብምጣኔአገልግሎትተጠቃሚዎችየሚቀርብሙጠይቅ፡

ኮድ	ጥያቄ	መልስ	እለፍ
218	የትኛውን የመከላከያ ዘዴ ነው የሚጠቀሙት?	1. ኪኒን 2. በመርፌ መልክ የሚሰጠውን 3. ፀረ ወንድ ዘርፍሬ (ፈሳሽ ቅባት) 4. ማሕፀን ቆብ 5. በማሕፀን የሚቀመጥ 6. ኮንዶም 7. በክንድላይ የሚቀበር 8. ሌላ (ይግለፁ).....	
219	አሁን ከሚጠቀሙበት የወሊድ መከላከያ ሌላ የትኛውን ዘዴ ውቃሉ?		
219.1	ኪኒን	1. አዎ 2. አይደለም	
219.2	በመርፌ መልክ የሚሰጠውን	1. አዎ 2. አይደለም	
219.3	ፀረ ወንድ ዘርፍሬ (ፈሳሽ ቅባት)	1. አዎ 2. አይደለም	
219.4	ማሕፀን ቆብ	1. አዎ 2. አይደለም	
219.5	በማሕፀን የሚቀመጥ	1. አዎ 2. አይደለም	
219.6	ኮንዶም	1. አዎ 2. አይደለም	
219.7	ማፀሕን ማስቆጠር	1. አዎ	

		2. አይደለም	
219.8	በክንድላይ የሚቀበር	1. አዎ 2. አይደለም	
219.9	ሌላ ካለ ይግለጹ.....	1. አዎ 2. አይደለም	
220	ባለፈው ይጠቀሙ በትየነበረው ንዋሊ ድመክላክያ ዘዴ ከዚህ የ ጤና ድርጅት ነበር የተጠቀሙት?	1. አዎ 2. አይደለም	
221	ከዚህ ካልሆነ ከየት ነበር የሚያገኙት?	1. ከሌላ የመንግስት ጤና ድርጅት 2. ከግል ክሊኒክ 3. መንግስታዊ ካልሆነ ጤና ድርጅት 4. ከመድሀኒት ቤት 5. ሌላ ካለ /ይግለጹ/	
222	ለወሊድ መክላክያ ዘዴው እና ለአገልግሎቱ ክፍለ ዋል?	1. አዎ 2. አይደለም	
223	የከፈሉ ከሆነ ለአንድ ጉባኤ ትምንት ያህል ከፈሉ?	1. ለወሊድ መቆጣጠሪያው ብር... 2. ለአገልግሎት ብር ----- -----	
224	የእርስዎ ዳኛ የወሊድ መክላክያ ዘዴ ለመውሰድ ቢፈልጉ ወደዚህ ህጤና ድርጅት እንዲመጡ ይገፋፋዎታል?	1. እዚህ ክሊኒክ እንዲመጡ ገፋፋለሁ 2. ሌላ ቦታ እንድሄድ እመክራለሁ 3. አላውቅም 4. መልስ አልተሰጠብኝም	
224.1	ወደ ሌላ ጤና ድርጅት እንድሄድ ከተገፋፋለሁ?		

224.2	ረጅምጊዜስለሚቆዩ	1. አዎ 2. አይደለም	
224.3	ሩቅበመሆኑ	1. አዎ 2. አይደለም	
224.4	ጥራትያለውአገልግሎትእዚህስለሌለ	1. አዎ 2. አይደለም	
224.5	የሚሰጠውየምክርአገልግሎትደካማናበቂስላልሆነ	1. አዎ 2. አይደለም	
224.6	ሌላካለ /ይግለፁ		
225	ከዚህየጤናተቋምየትኛውንአገልግሎትወደውታል?		
225.1	አገልግሎትበአጭርጊዜውስጥነውየሚያገኙት	1. አዎ 2. አይደለም	
225.2	አገልግሎትሰጪውጥሩአገልግሎትይሰጣል	1. አዎ 2. አይደለም	
225.3	የምክርአገልግሎትግልፅናአጥጋቢነው	1. አዎ 2. አይደለም	
225.4	የመረጡትንየመከላከያዘዴያነውየተጠቀሙት	1. አዎ 2. አይደለም	
225.5	ሌላካለ /ይግለፁ		

ክፍል IV:
በተለያዩወሊድመከላከያዘዴዎችላይያተከሩየእውቀትጥያቄዎች/ለአዲስናለተመላላሽተጠቃሚዎች
ለኪነንተጠቃሚዎች

ኮድ	ጥያቄ	መልስ	እለፍ
226	ኪነንመውሰድመቼነውመጀመርያለበት?	1. የወርአበባበመጣከ 1-5 ቀንውስጥ 2. በማንኛውምሰዓት 3. አላውቅም 4. መልስአልተሰጠም	

227	የወሊድ መከላከያ ኪነን በምን ያህል ጊዜ ልዩነት መወሰድ አለበት ?	<ol style="list-style-type: none"> 1. አንድ ኪነን በቀን በተመሳሳይ ሰዓት 2. በማንኛውም ሰዓት 3. በግብረሰታዎች ነጥብ 4. አላውቅም 	
228	የወሊድ መከላከያ ኪነን በሚወሰድበት ጊዜ ምን ዓይነት ቀለል ያሉ ሎች ግሮች ሊከሰቱ ይችላሉ?		
228.1	ችግር አይኖርም	<ol style="list-style-type: none"> 1. አዎ 2. አይደለም 	
228.2	ቀለል ራስ ምታት	<ol style="list-style-type: none"> 1. አዎ 2. አይደለም 	
228.3	መጠነ ጥንቃቄ ይኖራል	<ol style="list-style-type: none"> 1. አዎ 2. አይደለም 	
228.4	ማቅለሽለሽ	<ol style="list-style-type: none"> 1. አዎ 2. አይደለም 	
228.5	ያልተጠበቀ የደም ጠብታ በብልት መፍሰስ	<ol style="list-style-type: none"> 1. አዎ 2. አይደለም 	
228.6	ሌላ ካለ /ይግለጹ/		
በመርፌ መልክ የወሊድ መከላከያ ለሚወስዱ			
ኮድ	ጥያቄ	መልስ	እለፍ
229	በመርፌ መልክ የሚወስዱት የወሊድ መቆጣጠሪያ ጥቅም ተነግሮ ታል?	<ol style="list-style-type: none"> 1. አዎ 2. አላውቅም 	
230	በመርፌ መልክ የሚወስዱት የወሊድ መቆጣጠሪያ በየስንት ጊዜ ውነው መወሰድ ያለበት?	<ol style="list-style-type: none"> 1. በየወሩ 2. በየሶስት ወሩ 3. በየዓመቱ 4. አላውቅም 	

231	የወሊድ መከላከያ በመርፌ መልክ በሚወስድ በትጊዜ ከመደበኛ ቀጠሮ ዎው ጭምን አይነት ችግር ቢከሰት ነው ወደ ጤና ድርጅት ሊመለሱ የሚችሉት?		
231.1	ችግር አይኖርም	1. አዎ 2. አይደለም	
231.2	ከባድ ራስ ምታት	1. አዎ 2. አይደለም	
231.3	ከብልት ብዛት ያለው ደም መፍሰስ	1. አዎ 2. አይደለም	
231.4	ሌላ/ ይግለጹ		
በማሕፀን ዎው ስጥላ ሚቀመጥ መከላከያ ለሚወስደ			
ኮድ	ጥያቄ	መልስ	እለፍ
232	በማሕፀን ዎው ስጥላ ተቀመጠ ልዎት የወሊድ መከላከያ በቦታ ውስጥ ፍሩን እንዴት ነው የሚያረጋግጡት?	1. በብልት ውስጥ ክሮች መኖራቸውን በየጊዜ ውበመዳሰስ 2. አንድ ጊዜ በማሕፀን ከ ተቀመጠ ከዚያ በኋላ አይወጣም 3. አላውቅም	
233	በማሕፀን ዎው ስጥላ ተቀመጠ ልዎት የወሊድ መከላከያ ለመጀ መሪ ጉብኝት መቼ እንዲመጡ ተቀጠሩ ?	1. መመለስ ወይም ቀጠሮ አያስፈልግም 2. ከአንድ ወር በነሰ ጊዜ ውስጥ 3. ከወር በኋላ 4. ከአመት በኋላ 5. አላውቅም	
234	በማሕፀን ዎው ስጥላ ሚቀመጥ የወሊድ መከላከያ ከተቀመጠ ል ዎት በኋላ ምን አይነት ቀለል ያለ ችግሮች ሉኖርዎት ይችላሉ?		

234.1	ቸግርአይኖርም	1. አዎ 2. አይደለም	
234.2	ያልተጠበቀ የደምጠብታ በብልት መፍሰስ	1. አዎ 2. አይደለም	
234.3	ከብልት ላይ መጠነኛና ያልተለመደ ፈሳሽ መጨመር	1. አዎ 2. አይደለም	
234.4	ብክለት/ሀመም	1. አዎ 2. አይደለም	
234.5	ሌላ ካለ/ይግለፁ		
234.6	አላውቅም		
235	በሚሾም ወይም በሌላ ጥያቄ የወሊድ መከላከያ ለምን ያህል ጊዜ እርግዝናን ይከላከላል?	1. ለ12 አመት 2. ለ5 አመት 3. ለ3 አመት 4. አላውቅም	

በክንድላይ የሚቀበረው የወሊድ መከላከያ ለሚወስዱ

ኮድ	ጥያቄ	መልስ	እለፍ
236	በክንድላይ የሚቀበረው የወሊድ መከላከያ በስንት ጊዜ መቀየር አለበት?	1. በየአምስት አመት 2. በየሁለት አመት 3. በየሶስት አመት 4. በየአራት አመት 5. አላስታውስም	
237	በክንድላይ የሚቀበረው የወሊድ መከላከያ ዘይቤ ጥቅም ተነግሮ ያታል?	1. አዎ 2. አልተነገረኝም	
238	በክንድላይ የሚቀበረው የወሊድ መከላከያ ከመደበኛ ቀጠሮዎ ውጭ ምን ዓይነት ችግር ቢከሰት ነው ወይም ነድር ጅት ሊመለሱ የሚችሉት?		
238.1	ቸግርአይኖርም	1. አዎ 2. አይደለም	

238.2	ከፍተኛ እራስ ምታት	1. አዎ 2. አይደለም	
238.3	ብዛት ያለው ደም መፍሰስ	1. አዎ 2. አይደለም	
238.4	ክብደት መጨመር	1. አዎ 2. አይደለም	
238.5	ሌላ ካለ/ይግለፁ		

አጠቃላይ የደንበኛ እርካታን መለኪያ / ለአዲስ ናተመ ላላ ሽደን በኛ/

ኮድ	ጥያቄ	መልስ	እለፍ
239	የወሊድ መከላከያ ዘዴው እንዴት እንደሚሰራ በግልፅ ተነግሮታል	1. አዎ 2. አይደለም	
240	አገልግሎት ሰጪው ለሚሰራቸው ሥራዎች ጥሩ እውቀትና ችሎታ አለው?	1. አዎ 2. አይደለም	
241	አገልግሎቱ ሲሰጠው ጥሩ የዳዲኝነት ስሜት ነበር? / ደህና አደር ሽወደም ደህና ዋል ሽ በማለት ሰላምታ ሰጥተዎታል?	1. አዎ 2. አይደለም	
242	በምክር አገልግሎት ጊዜ ለብቻ ዎና አመች ሁኔታ ተፈጥሮ ልዎት ነበር? ሌላ ተገልጋይ እርስዎ የሚያወሩትን አይሰማም/አያይም	1. አዎ 2. አይደለም	
243	ለቤተሰብ ምንም እንኳን አገልግሎት ሰጪው ጥያቄና ማብራሪያ የማቅረብ ዕድል አግኝተው ነበር?	1. አዎ 2. አይደለም	
244	በቂ የወሊድ መከላከያ ዘዴዎች ነበሩ	1. አዎ 2. አይደለም	
245	አገልግሎት ሰጪው ለሚቀጥለው ቀን ጠሮ ዎ የመመለሻ ቀን ሰጥተዎታል?	1. አዎ 2. አይደለም	
246	አገልግሎቱ የሚሰጥበት ክፍል ንፅህናው የተጠበቀ ነው?	1. አዎ 2. አይደለም	
247	አገልግሎት እስኪያገኙ የቆዩበት ቦታ ለፀሃይና ለዝናብ አሌተጋለጡም	1. አዎ 2. አይደለም	
248	በሌሎች የድርጅቱ ሰራተኞች የተደረገ ልዎት አቀባበል ጥሩና የዳዲኝነት ስሜት ነበረው	1. አዎ 2. አይደለም	
249	አገልግሎቱን እስኪያገኙ በተቋሙ የቆዩበት ሰዓት በቂ ነበር	1. አዎ 2. አይደለም	

አመሰግናለሁ !!