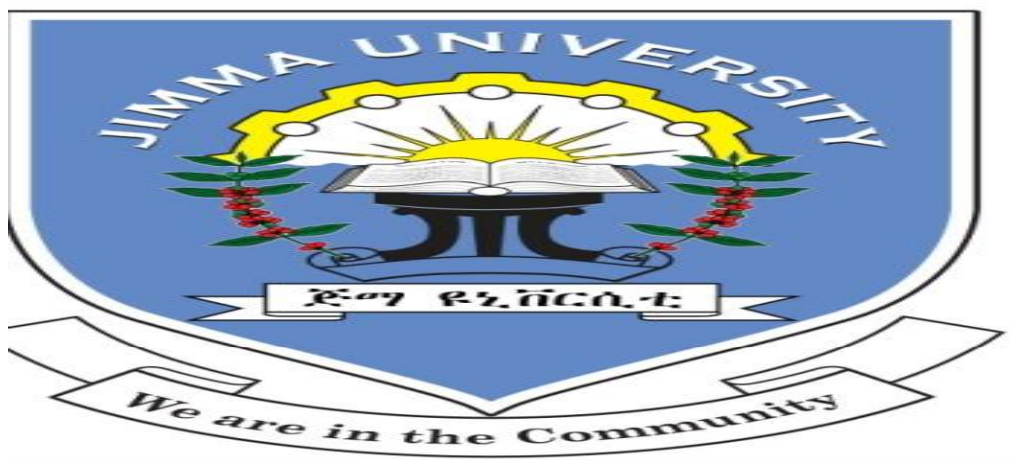


Client's Satisfaction Towards Family Planning Services and Associated Factors among Family Planning Users in Hossana Town Public Health Facilities, South Ethiopia



BY

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THESIS SUBMITTED TO JIMMA UNIVERSITY, COLLEGE OF PUBLICHEALTH AND MEDICAL SCIENCES, DEPARTMENT OF NURSING; IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER IN MATERNITY NURSING.

May, 2014

JIMMA, ETHIOPIA

Jimma University
College of Public health and Medical sciences
Department of Nursing and Midwifery

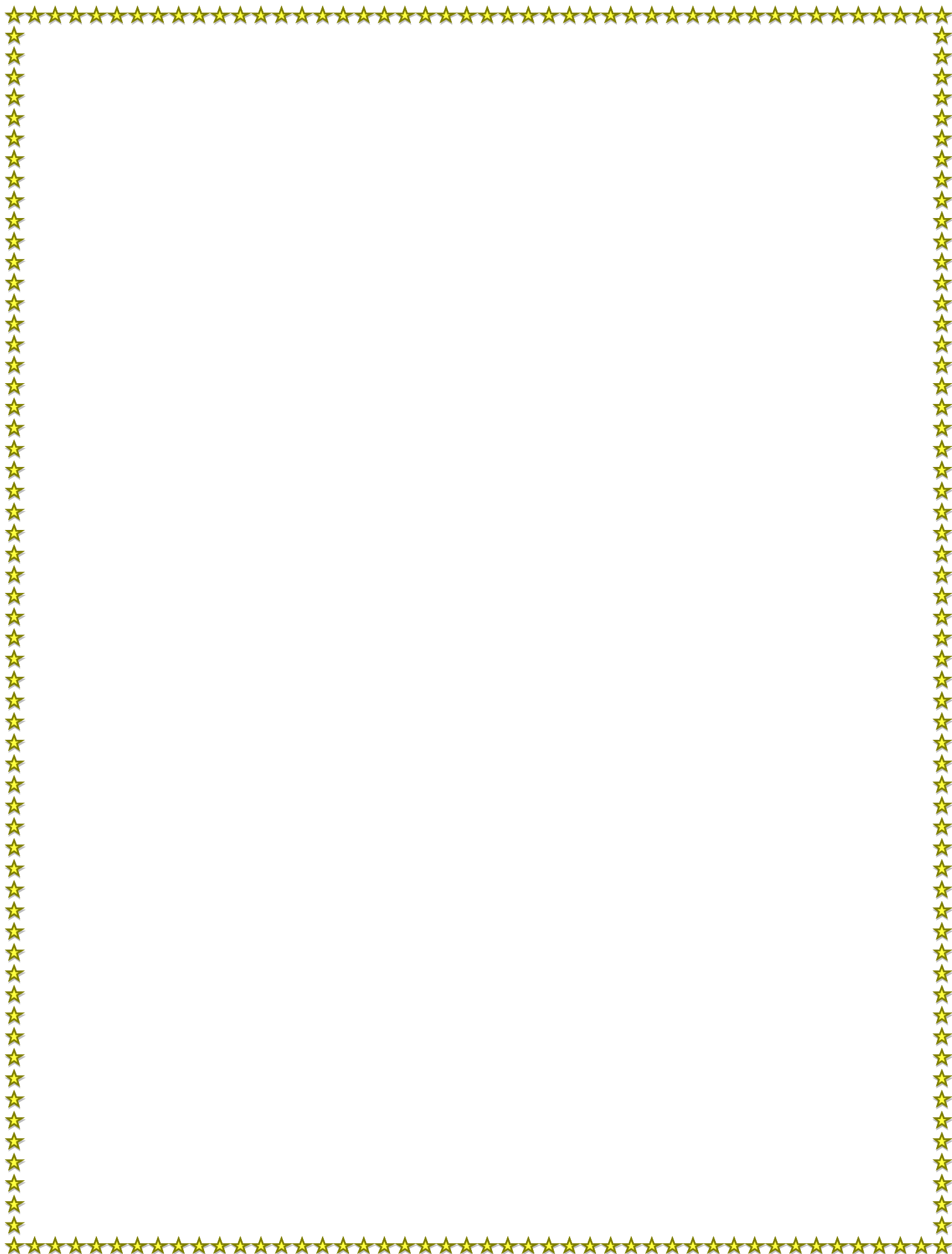
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Ethiopia

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ABSTRACT

Background: Client satisfaction is considered as one of the desired outcomes of health care and it is directly related with utilization of health services. Contraceptive discontinuation for quality related reasons is relatively common event in all countries. Within a year of starting use of a method, between 9% and 34% of women stop using contraception for reasons related to the quality of the service.

Objective: The objective of this study was to assess clients' satisfaction with family planning services and associated factors in public health facilities in Hossana Town, South Ethiopia.

Methods: Facility-based cross-sectional study that involved an exit interview was conducted from February to March 2014 in public health facilities in Hossana town. The data were collected from 324 respondents selected by systematic sampling technique using pre-tested structured interviewer administered questionnaire. Descriptive statistics, bivariate analysis and multivariable logistic regression analyses were employed to identify factors associated with satisfaction.

Results: Of the total 324 study subjects, 75.3% of the respondents were reported as they were satisfied with services they received. In multivariable analysis, satisfaction of clients was higher for those women who reported their waiting time to be 30 minute and less (AOR=5.5 [95%CI=1.918, 15.77]), those for whom privacy was ensured during exams and procedures (AOR=5.08 [95%CI=2.270, 11.387]), told how to use the method (AOR=3.431[1.206, 9.761]), had history of unintended pregnancy (AOR 2.803[1.058, 7.426]), repeat users (AOR=3.041[1.37, 6.737]), perceived convenient opening hours (AOR= 4.730[1.217,18.383]) and lower for those women who perceived health Facilities not clean (AOR= 0.192[.056, .658]) and those who had experienced methods side effect (AOR=0.280 [95%CI= [.121, .645].

Conclusion and recommendations: This study revealed that clients' satisfaction with family planning service was 75.3%. Improving information provision and proper handling of clients was recommended. It is suggested that creating mechanism to reduce long waiting time can improve client satisfaction.

Key words: family planning, client satisfaction, Hossana town

ACKNOWLEDGMENTS

First, I would like to express my deepest gratitude to my advisors Professor Kifle Woldemichael and Mr. Sena Belina for their contributions and constructive comments they have provided during the whole course of the research.

I would also like to extend my thanks to Jimma University College of Public Health and Medical Sciences, Department of Nursing for providing me the opportunity to carry out this study.

My appreciation goes to data collectors and supervisors for their active participation in the study

I would also like to extend my gratitude for Hadiya zone health department, Hossana town health office and study participants for their valuable contribution in the realization of this study.

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List of Abbreviations and Acronyms

CPR	Contraceptive prevalence Rate
EDHS	Ethiopian Demographic Health Survey
ETB	Ethiopian Birr
FGAE	Family Guidance Association of Ethiopia
FGD	Focus Group Discussions
FP	Family planning
HF	Health Facilities
HSDP	Health Service Delivery Points
IUCD	Intra uterine contraceptive device
MDGs	Millennium Development Goals
NEMMH	Nigist Elene Mohammad Memorial Hospital
OR	odds ratio

CHAPTER ONE: INTRODUCTION

1.1 Background information

Currently, the world population is growing by over 80 million people every year. According to the UN projections, by 2025 the world would contain over 8 billion people, of which some 6.8 billion would live in developing countries (1). Fertility is highest among sub-Saharan African countries at an average of 5.3 children per woman. Ethiopia is one of the sub-Saharan African countries with alarming population growth rate 2.6 and total fertility rate is approximated 5 (2). Family planning services are unique in providing the means for couples to space or limit their births, as well as to stabilize the world's population. They also have a role in the reduction of maternal morbidity and mortality by their ability in reducing the absolute number of pregnancies among all women, reducing the number of pregnancies among high-risk women, and reducing the number of unwanted pregnancies that might otherwise end in abortion (3). The Promotion of FP in countries with high birth rates has the potential to reduce poverty and hunger and prevent 32% of all maternal deaths and nearly 10% of childhood deaths (4).

The Ethiopian population policy, which was adopted early 1993, one of targets of the Ministry of Health is to reduce the total fertility rate; reducing morbidity and mortality, with respect to improving maternal and child health, is to increase the contraceptive prevalence rate (CPR) to 66 percent by 2015. In order to achieve this target, the Ministry has given priority to the provision of safe motherhood services such as family planning in the community(5,6)

The need for FP service in Ethiopia is evidenced by its population growth, morbidity and mortality statistics. With a population of nearly 83 million in 2010; Ethiopia is the second most populous country in Africa next to Nigeria. Due to rapid population growth, systematic provision of FP service had begun in 1966, when the Family Guidance Association of Ethiopia (FGAE) was established as Non-Governmental, non-profitable organization by small group of concerned individuals (5).

Increasing access to and use of FP is not one of the Millennium Development Goals (MDGs); but it can make valuable contributions to achieving many of the goals. Increased

contraceptive use can significantly reduce the costs of achieving selected MDGs and directly contribute to reductions in maternal and child mortality (6).

Living in the world of information and technology, nowadays patients are aware of their needs and rights. They know that health care facilities are established to provide satisfactory and quality health services to them. If the health care facilities fail to do so, they are considered unsuccessful in implementing their assigned tasks. Health care facility performance can be best assessed by measuring the level of patient's satisfaction. A completely satisfied patient believes that the organization has potential in understanding patient needs related to health care (7).

The quality of care measured from the perspectives of clients or providers, is believed to influence reproductive health outcomes through improved client satisfaction and contraceptive use behavior. Client satisfaction with services is a subjective way of measuring quality of FP services. Satisfied clients are more likely to re-visit the services, pass on positive messages by word of mouth to others, and continue use of a particular FP method. On the other hand, dissatisfied clients are more likely to share their negative experiences with others and are less likely to return or continue use of FP services (8). Improved quality of care is an increasingly important goal of international FP programs, for a variety of compelling reasons. Improving the quality of services that women receive is expected to have an impact on women's satisfaction with the services, on their continued use and, ultimately, on their ability to achieve their fertility goals or reproductive intentions. Providing quality services will lead to increased service utilization by more committed users resulting in higher contraceptive prevalence rate(CPR) and lower fertility (9).

Client satisfaction is considered as one of the desired outcomes of health care and it is directly related with utilization of health services. Client satisfaction is the level of satisfaction that clients experience having used a service. It therefore reflects the gap between the expected service and the experience of the service, from the client's point of view. Measuring client satisfaction has become an integral part of management strategies across the globe. Client satisfaction is a fundamentally important measure of the quality of care because it offers information on the provider's success at meeting those expectations of most relevance to the client. Measures of satisfaction are, therefore, important tools to evaluate administration and planning the process of health care (10) .

1.2 Statement of the problem

Numerous studies have examined the effects of FP quality on the uptake and continuation of FP methods. One principal determinant of uptake and continued utilization of FP services is overall client satisfaction with those services. Studies of contraceptive discontinuation rates, for example, have indicated that - with the exception of the desire to become pregnant - the principal reason for discontinuation is dissatisfaction with the quality of services (11).

The discontinuation rates are highest in sub-Saharan Africa where the majority of women have discontinued using contraception. In Ethiopia in 2000 51%, in 2003 Burkina Faso 54%, Kenya 39%, Ghana 54%, Nigeria 59% ,Cameroon in 2004 in 54%, Rwanda in 2001 63% and Eritrea 2002 64% were discontinued contraceptive use. In countries outside of sub-Saharan Africa, the discontinuation rates vary between 19% and 36%. Method-related reasons were the second most frequently cited reasons for discontinuation of contraception. These included wanting a more effective method, health concerns, side effects, lack of access, cost, and inconvenient to use (12).

Contraceptive discontinuation for quality related reasons emerges as a relatively common event in all countries. Within a year of starting use of a method, between 9% and 34% of women stop using contraception for reasons related to the quality of the service environment. Between one half and three quarters of all discontinuations are due to these reasons(13).

Contraceptive discontinuation is clearly a critical factor in unintended pregnancy, not all discontinuation results in this outcome and reducing the level of discontinuation will be challenging in light of the ambivalence about both contraceptive options and pregnancy intentions (14).

Discontinuations of contraceptive methods for reasons related to the method or the service environment are relatively common events. Discontinuations for these types of reasons are of particular significance because they potentially put women at risk of an unintended pregnancy. Within three months of discontinuing a modern reversible method for method- or service-related reasons, the vast majority of users between 60% and 88% have adopted a new method, returned to the same method or become pregnant. In a number of countries, substantial proportions of women switch to a traditional method after discontinuing a modern method for method- or service-related reasons (13).

Unplanned pregnancy poses a major public health challenge in women of reproductive age, especially in developing countries. It has been estimated that of the 210 million pregnancies that occur annually worldwide, about 80 million (38%) are unplanned, and 46 million (22%) end in abortion (15). In 2008 the average pregnancy rate of the 215 million women in developing countries who wanted to avoid pregnancy but were using either no method or a traditional method was 288 per 1,000 (16). By 2008, the unintended pregnancy rate in the less developed world was one-third higher than that in the more developed world 57 per 1,000 women aged 15–44. The unintended pregnancy rate in the developing world was 60% higher than that in the developed world. Roughly half of all unintended pregnancies ended in abortion 53% of those in more developed regions and 48% of those in less developed regions (4).

In developing countries maternal mortality is the leading cause of death for women of reproductive age, in parts of Sub-Saharan Africa there are more than 1500 maternal deaths for every 100,000 live birth. Unsafe abortion is the cause for one in every four maternal death and in some countries as high as 50% (17).

In Sub-Saharan Africa, only 17% married women of reproductive age use a modern contraceptive, even though a far higher proportion want to avoid becoming pregnant soon or ever. Thirty-nine percent of pregnancies in the region are unintended, ranging from 30% in Western Africa to 59% in Southern Africa. In 2008, about 60% of women (47 million) in the region who wanted to avoid a pregnancy either were not using family planning or were using a traditional method. These women accounted for 91% of unintended pregnancies (18). The 2011 EDHS reveals that 25% of married women have an unmet need for family planning, 16% of women have a need for spacing births and 9% for limiting births (19). The CPR in Ethiopia is about 28%. The few surveys conducted on issues related to abortion and unwanted pregnancy suggest that the magnitude of unwanted pregnancy and unsafe abortion are among the main causes of maternal mortality in Ethiopia (20). In 2008, 101 unintended pregnancies occurred per 1,000 women aged 15–44, and 42% of all pregnancies were unintended. In the same year an estimated 382,500 induced abortions, 23 abortions per 1,000 women aged 15–44, were performed in Ethiopia (21).

CHAPTER TWO: LITERATURE REVIEW

In this chapter, literature regarding factors influencing the client satisfaction with family planning services will be reviewed. It is hoped that the information gained from the previous studies will provide a framework for an analysis that follows.

2.1 Over view on level of client satisfaction with family planning service.

Cross-sectional studies in rural Bangladesh (2001) showed that a significant proportion of users (34.2%) were not satisfied with the length of time that the facilities were open to the public. About a third (28.2%) of all users was not satisfied with the time they waited to receive care. Moreover, patients presenting for maternal care were significantly more dissatisfied (37.6%) than clients presenting for other types of services. multivariate analysis did demonstrate that satisfaction with the politeness of the provider was the most powerful predictor variable, followed by satisfaction with the provider's respect for privacy, waiting time, and consultation time. Satisfaction with the provider's usual behavior was expressed by 68.9% of patients. A total of 68% of patients expressed satisfaction with the services usually render, but almost half (45%) the clients presenting for female care were not satisfied at all (22). A cross sectional study in Thailand Community Hospital (2007) showed that satisfaction level was found that 23.3% of the patients were highly satisfied and 61.4% of them were moderately satisfied. Only 15.3% of patients were lowly satisfied with health services at the clinic (7). A cross sectional study in Islamabad (2005) showed that level of the satisfaction was slightly more than half (54%) patients were satisfied. When distribution of percentage of overall satisfaction was analyzed by group it could be assessed that low satisfaction was mainly attributed due to poor physical facilities (47%), lack of medical equipments (35%) and poor pharmacy services (35%) and inadequate doctor service (38.5%)(23).

A descriptive cross-sectional study in Colombo district, Australia (2008), client dissatisfaction with the condition of the waiting area (22%), lack of cleanliness in the clinic (20%), and inadequate toilet facilities (49%) were noted. Though clinics are conveniently located for the majority (98%), one-third of clients had to wait more than one hour to be seen by a provider (24). A cross sectional study conducted in Amhara region (2005) show that highest satisfaction rate (93.8 %) was associated with the courtesy of the health care

providers. About 25.2% of the clients were dissatisfied with the provision of information about the hospital services and their health problems (5).

Quantitative, Cross-Sectional descriptive study in Tikur Anbessa General Specialized Hospital (2005) showed that 75.8% of FP clients rated the services received as 'Very satisfactory'(25). Cross sectional study conducted in Jimma University specialized Hospital (JUSH) show that the overall satisfaction level of the clients with the services rendered at was 77.0 % and 37.2% of the clients were dissatisfied by the overall waiting time to get the services(10).A recent study in Jimma zone (2013) showed that 93.7% of the clients were satisfied in the family planning services they were provided with(26).

2.2 Maternal Socio-demographic & Economic factors

The results of Slovenia Cross-sectional study showed that quality of care as assessed by the clients in terms of overall client satisfaction does not differ significantly regarding their ethnic backgrounds(27).Cross-sectional studies (1999) in Eastern Saudi Arabia showed that literacy status of the respondents also showed a consistent pattern of association with four of the six components. Those who are less literate were generally more satisfied. Literacy status also influenced satisfaction with the waiting area structure, with 69% of those illiterate being satisfied with the waiting area structure in their centers as compared with 47% of the literate participants. Nine out of 10 regular users were satisfied as compared with a 79% satisfaction rate amongst infrequent users. Perhaps more importantly, only 54% of infrequent users were satisfied with the explanation dimension whilst satisfaction with this aspect amongst frequent users was 72% (28).

(28). Women who had children were more likely to consider provider continuity important than women without children. However, women with a high school education or less had reduced odds of considering provider continuity important compared to women with more than a high school education. Age, parity and education were all associated with women's preferences regarding the site where reproductive health services are delivered. Women under 30 were less likely than those over 30 to prefer receiving reproductive health care at a site delivering general health care. Regarding parity, women with parity of 1 to 2 compared to those who had no children were less likely to prefer receiving reproductive health service at a site delivering general health care (29). A cross sectional study in Bangladesh (2007) showed that the relationship of age with satisfaction was analyzed. It was concluded that age had no significant association with satisfaction. Regarding the education, the result showed that in

the secondary or more level 18.5% was low satisfied. The percentage of no education was very close to each other and it was 16.3%. However the association was not significant. Regarding number of children it was found that, those who had less than one child among them, 39.0% highly satisfied and those who had more than three children, 35.4% highly satisfied. However, there was no association between number of children and satisfaction(30). A cross sectional study in Islamabad (2005) determined that patients who belonged to 'primary and lower' education level, were more satisfied than the secondary and higher group and the association was significant at $p\text{-value}=0.047$. In the occupation category, government employed group was found more satisfied than the other groups. Statistical association was significant with $p\text{-value}=0.000$. Patients having family members four or less tended to have more satisfaction than the other group having five or more family members statistical association was significant at $P\text{-value}= 0.025$ (23)

A cross-sectional study in Iran (2010) result showed that independent variables including job rank, number of children ever born, number of unintended pregnancies, duration of using contraceptives, being affected by side effects, expectations being met, degree of knowledge about contraceptives have significant relationships with dependent variable (satisfaction of services). However there are not any significant relationships between family income and family education as well as women's age with their satisfaction. Two most influential factors are expectations which have been met and side effects of using contraceptives. While the first affect is positively the seconds' impact is negative (31).

A cross-sectional survey in Ghana (2006) showed that prior knowledge of health care and marital status is also associated with higher levels of satisfaction while mothers with at least secondary education are more likely to be dissatisfied. It is apparent that younger women (20-24 years) and older women (40+ years) are less likely to be very satisfied with health care. It is also evident that rural dwellers are 8 percentage points less likely to be very satisfied with health providers (32).

Cross-sectional studies in West Showa (2009) showed that Socio-demographic variables were found to explain 3.9% of the variability in the satisfaction factor score. Accordingly, marital status, residence, educational status and occupational status appeared to be statistically significantly associated with satisfaction. The satisfaction score for single respondents was decreased as compared to their married counterparts. Urban residents had greater satisfaction score when compared to those from the rural area ($p\text{-value}<0.001$) (33).

Another study in Hawassa University Referral Hospitals (2008) showed that a significant association was found between overall patient satisfaction and the socio-demographic variables: age of patient, educational level of patient, monthly income and occupation of patient (34). A cross sectional study in Jimma zone (2011) showed that the significant predictors of client satisfaction to family planning services were educational level of the clients, perceived sufficiency of consultation and perceived facilitated service, whereas marital status, tendency to have more children, discussion of FP with husband/partner, occupation of the clients, religion, residence, and age of the clients, and waiting time were not. As educational level of the clients increases, client satisfaction score to family planning services increases significantly ($P=0.01$). For a unit increase in perceived sufficiency of consultation, the satisfaction score on average increases significantly ($p<0.001$). For a unit increase in perceived facilitated-service the satisfaction score increases significantly ($p<0.001$) (26).

2.3. System-related factors

A cross sectional study in Kenya, Ghana and Tanzania (2011) showed that availability of a range of methods of contraception has been considered a central element of quality of care because it is likely to influence client satisfaction, contraceptive acceptance and continuation. Cleanliness of the facility, how the staff treated, Cost for services or treatment, waiting time, availability of medicines or methods at facility and hours of service at facility are significantly associated (11).

A cross sectional study in Bangladesh (2007) showed that 39% of the respondents were highly satisfied with the services of the hospital. 47% of the respondents were moderately satisfied. Only 14% of the respondent's satisfaction level was low. So the relationship between available service facilities and satisfaction of mothers was found significant (p -value = 0.009). Those who access good service facilities, tend to be satisfied more than those who accessed poor service facilities. Majority of the respondents (71.4%) told the availability of the waiting place was less than enough. 26.3% respondents told the availability of the waiting place were enough. Only 2.3% women were satisfied with the waiting place and told the waiting place was more than enough. The percentage about the availability of drinking water was almost similar 52% told drinking water was enough, where as 48% told drinking water was less than enough and 21.1% of the respondents told the toilet was fully clean, where as 22.9% told the toilet was totally unclean. But 56.0% told the toilet was partly clean. Majority

(52.6%) had to wait for longer time to get the service from the hospital, where as 41.1% women had to wait for reasonable time. Only 6.3% women had to wait for less time to get the desired service from the hospital (30).

Descriptive cross-sectional study in Urmia (2008) showed that almost all the women (93.3%) indicated satisfaction satisfied that their choice of FP method was free and informed. More than half the women (56.1%) were satisfied with the information about the limitations of the FP service and the preventive methods, while 28.3% of them were completely unsatisfied or unsatisfied. The most unsatisfactory aspects of reproductive health services were the items “information about limitations of contraceptive service” (28.3% of women unsatisfied) and “information about referral services” (29.7%). Concerning provider skills, the majority of women (86.6%) had high satisfaction with the experience of the FP provider, while one-third (34.0%) were unsatisfied with the provider they had selected(35).

A cross sectional study in six region of Ethiopia showed that (2008) type of health facility was statistically significant in determining satisfaction to cleanliness of the facilities. These could imply that study participants who were divorced or widowed were 45% less likely to have high satisfaction on cleanliness of the facilities than those who were married. Age , level of education and the types of health facility were significantly associated high satisfaction on cleanliness of the facilities As to the types of health facility, respondents who utilized services from the health centers were 3.09 times more likely to have high satisfaction on cleanliness of the health facility than those study participants from the hospitals(36). A cross sectional study in JUSH (2011) showed that there was statistically significant association between client’s satisfaction and their age ($p=0.034$), their educational status ($p=0.003$), occupational status of the respondents, ($p=0.002$), address of the respondents ($p=0.000$), payment scheme of the respondents ($p=0.000$) and waiting time to see a doctor ($p=0.000$) (10).

2.4. Health provider- related factors

Descriptive cross sectional study in Uremia (2008) showed that information given to clients ,informed choice about FP method, interpersonal relationship, provider skills ,consistency and follow-up and comprehensive service were significantly associated with mothers satisfaction ($p\text{-value} < 0.001$). Majority of women (92.5%) were satisfied that the behavior of the service provider was polite, while 29.2% of them were unsatisfied with the item about the use of educational tools in the consultation. The majority (83.0%) of women had satisfied

that they had enough information about follow-up visits. Concerning consistency and follow-up of service, 8.2% of women were unsatisfied about the item.

A cross-sectional study in Bangladesh (2007) showed that respondents who received good and fair services from the service provider, 38.1% were highly satisfied. But the respondents who received poor services from the service providers, 46.4% were also highly satisfied. However, there was nearly significant association with available service-related to providers and satisfaction of mothers who received services (P-value 0.052). There is insufficient evidence to conclude that available service related to providers associated with the level of satisfaction. Majority of the respondents (76.6%) told the available services of the hospital-related to providers were fair and 7.4% told the provider's support was good. Only 16.0% respondent was not satisfied with the available services of the hospital and told the provider's support was poor (30).

A cross-sectional comparative study in Kenya (2009) showed that Process aspects of quality, both interpersonal and technical were associated with client satisfaction. An assurance of the confidentiality of the visit was, in particular, associated with higher client satisfaction. A provider's assurance of confidentiality may be particularly important for a woman who wants to use the Injectable without informing her husband. The odds of a client being satisfied were higher at a facility where a provider received a higher score on taking a reproductive history and conducting a physical examination. Structural aspects of counseling and provider motivation were important determinants of client satisfaction(37).

A 2011 Kenyan survey revealed that FP clients reported less visual and aural privacy during their examinations than those seeking other services, with the percentages of (visual privacy, 17 percent; aural privacy, 6 percent) in public facilities. In contrast, more than three-quarters of the clients believed the information they shared with the provider would be kept confidential. Less than a half of the clients reported that the provider treated them very well during their visit in public facilities (FP clients, 30 percent) (38).

Perceived quality of care at the clinic was weakly related to first-method continuation. Method users who reside in areas characterized by high quality of care were 22 percent less likely to continue their first method, perhaps because higher quality clinics offer a broader range of methods to choose from, and providers may encourage users to switch methods if they are dissatisfied with their first choice (39). A 2011 Kenyan survey showed most of

satisfied clients (at least 94 percent) reported they would use that facility for health care services in future and would recommend it to family/friends (38).

A cross-sectional study (2008) in Addis Ababa showed that provider's politeness, consultation time and provider's satisfactory response were significantly associated with maternal satisfaction. Participants who experienced long waiting time were less satisfied than those who said the waiting time was good. About one fourth of clients claimed that the waiting time for service was very long. Clients who were not treated politely by the providers were less satisfied than those who were treated politely. Privacy was maintained for 97.3% of Clients. Those who did not get satisfactory response for their questions were less satisfied than those with short consultation time were less likely to be satisfied than clients with adequate consultation time (40)

2.5 SIGNIFICANCE OF THE STUDY

As client satisfaction with family planning service was not assessed adequately, this study will provide direction and also helpful for improving the services in Ethiopia. The findings of the study will in general help the health management at a higher level and in particular those looking after the health institutions in the region to understand the extent of the problem in the health institutions. The study will enhance the capacity to look for possible alternative solutions to health service delivery of Ethiopia. It will also contribute to increase in the knowledge and awareness of the problem areas by concerned bodies including the health institution staffs. In addition, the paper may be useful to other researchers as reference material while conducting further studies on similar problems.

2.6 Conceptual framework

According to Bruce framework, satisfaction with services includes six elements of qualities (choice of methods, information given to clients, technical competence, interpersonal relations, and mechanisms to encourage continuity and appropriate constellation of services).

Based on Alden *et al* framework and Turner theory, individual satisfaction of received services depends on the degree of her expectations as an intermediate variable in the model. Also two other variables of Turner theory are helpful for model: individual's social status and experience of previous interactions. So, client's social status and their previous experience with family planning center are two variables which indirectly affect satisfaction.

Based on Aday and Andersen framework, job status, education and income are directly related to satisfaction. So, client's socioeconomic status directly influences satisfaction.

Finally, we regard level of clients' knowledge about contraceptive as an intermediate variable in a model. This variable has relationship with socioeconomic status, experience of previous interactions and affects expectations.

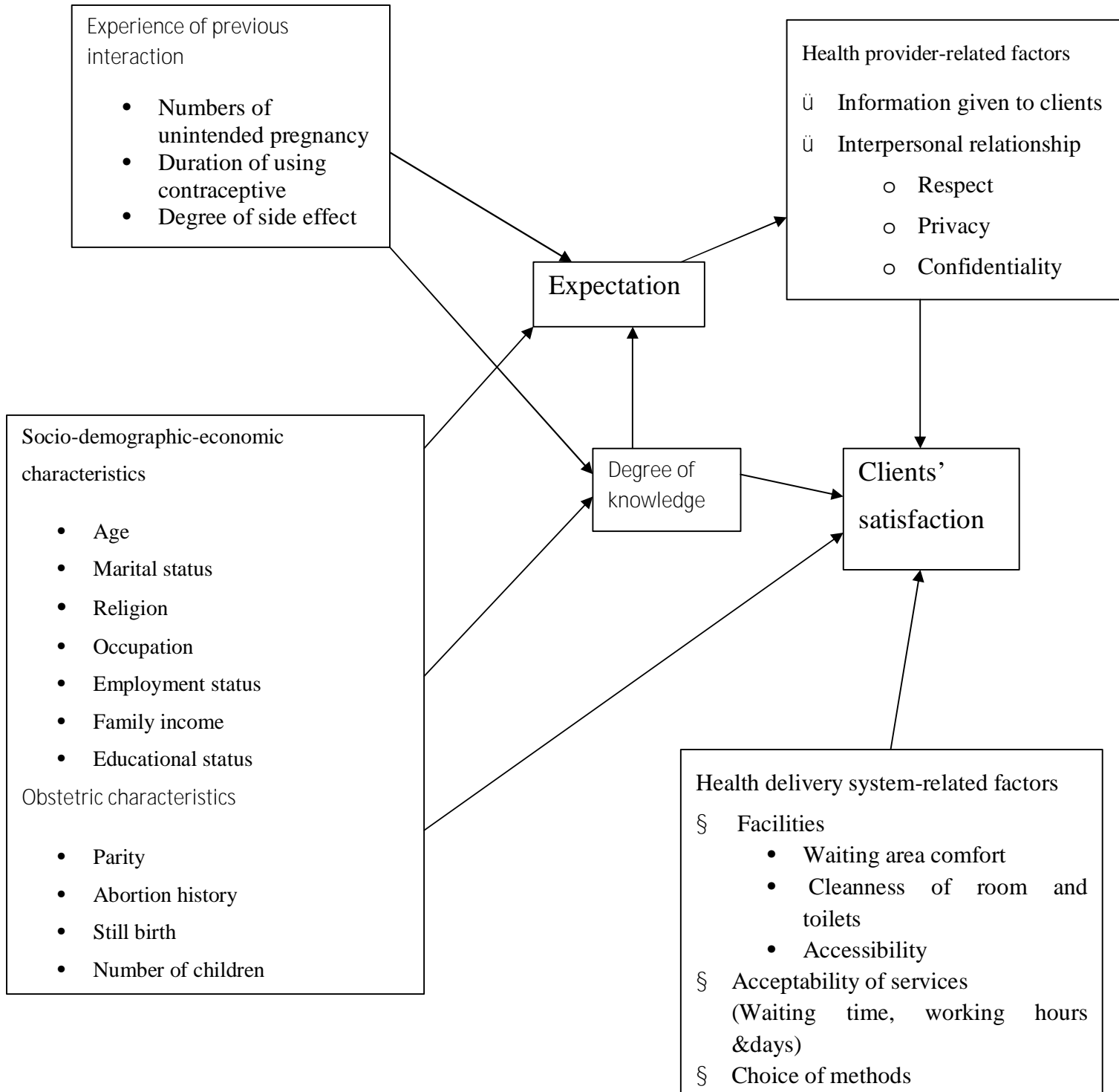


Figure 1 Conceptual Frameworks adapted from J.Bruce 1990, M. T. Iman and Shafieh Ghodrati 2010

CHAPTER THREE: OBJECTIVES OF THE STUDY

3.1. General Objective

The general objective of this study was to assess level of client satisfaction with family planning services and associated factors among family planning users in Hossana Town, South Ethiopia, 2014.

3.2. Specific objectives:

To determine level of clients satisfaction with family planning services among family planning users in Hossana Town.

To identify factors affecting the clients' satisfaction in family planning services among family planning users in Hossana Town.

CHAPTER FOUR: METHODS and MATERIALS.

4.1 Study area and period:

This study was conducted in Hossana town health facilities from February 18 to March 18 2014. Hosanna town is located 230 km south west from the capital city of Ethiopia Addis Ababa and 194 km far from regional city Hawassa being the capital of Hadiya zone. There are three sub-cities and 8 kebele's in the town. According to the housing and population census conducted in 2007, the total population size of the town as projected to the year 2013 is 102,238 of which 50,097 are males, 52,141 are females, 23,821 are reproductive age women and 3987 are pregnant women. The proportion of non-pregnant women constitutes 19.9% of the total population.

As to the health service facilities, there are four governmental health facilities: One hospital, three health centers and 16 private clinics.

4.2 Study design:

An institution based cross sectional study was conducted from February 18/2014 to March 18/2014. In this study both quantitative and qualitative methods of data collection were used.

4.3 Population and sample

4.3.1 Source population:

All female age 15-49 years who visited the Hossana town public health facilities for family planning services from Feb 18/2014 to March 18/2014.

4.3.2 Study population

All sampled mothers among family planning using clients visited in Hossana public health facilities during the study period (Feb 18/2014 to March 18/2014).

4.4. Inclusion and Exclusion criterion

4.4.1 Inclusive criteria

All female family Planning users at the time of data collection were included in the Study.

4.4.2 Exclusive criteria

Female family planning users who were severely sick to interview was excluded from the study.

4.5. Sample size determination and sampling technique:

4.5.1 Sample size determination:

The sample size (n) required for the study was calculated using a single population proportion

$$n = \frac{z \left(\frac{\alpha}{2} \right)^2 * P(1 - p)}{d^2}$$

Where:-

n= required sample size

$Z_{\alpha/2}$ = critical value for normal distribution at 95% confidence interval

Which equals to 1.96 (Z value at alpha=0.05).

P = 0.5, since the level of client satisfaction with family planning is not known,

P taken as 50%

d= Margin of error.

With the assumptions of 95% Confidence interval, 5% desired precision, prevalence 50.0% (P=0.50). The formula yields n=**384**

Since the number of FP clients i.e. source population (N) is 1429 (<10000) correction formula was used as follow

$$n_f = \frac{n}{1 + \left(\frac{n}{N} \right)} = \frac{384}{1 + \frac{384}{1429}} = \frac{384}{\frac{1813}{1429}} = \frac{384 * 1429}{1813} = 303$$

Adding non response rate of 10%, a total sample size of 303+31= **334** mothers who come for FP service was selected.

- For quantitative study 334 clients and 32 individuals those didn't participated in quantitative study were selected for qualitative study and categorized into 4 Focus Group Discussions (FGD) of equal size.

4.5.2 Sampling technique

The total sample was 334 FP clients at 4 public health facilities. According to the data obtained from the Hossana health facilities the annual family planning clients' is estimated to be 8,571. Sample size was determined proportionately to each health facilities. The study population was selected using systematic random sampling technique. On first day of data collection, the first participant from first four clients was randomly selected by using lottery method. Exit interviewing was conducted every 4th clients who received service. For qualitative study 4 Focus Group Discussions were conducted in two health facilities (Hospital and one HC) among clients who didn't participate in the quantitative study in the same time period and selection was performed purposively based on frequency of visits as homogeneity criteria.

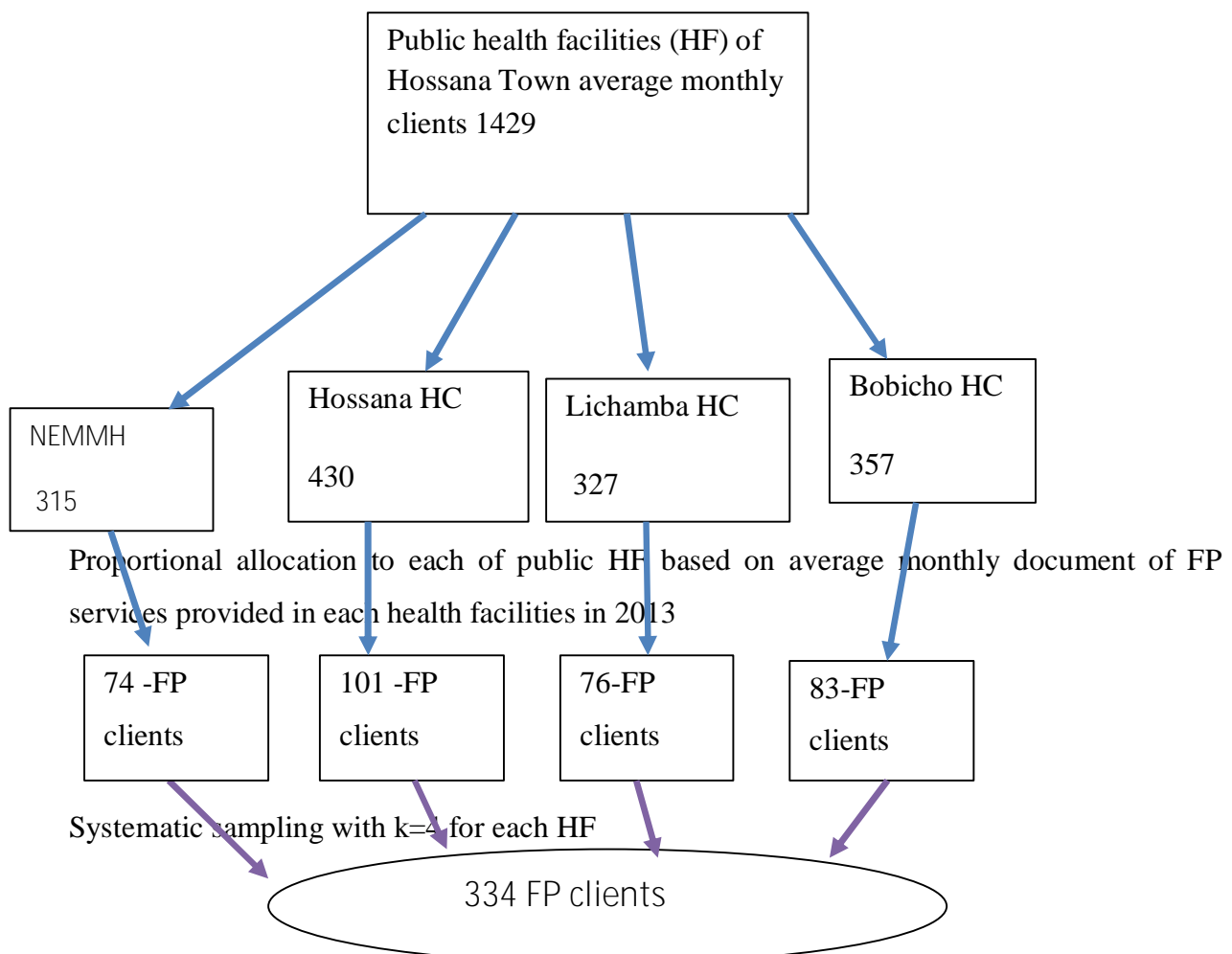


Figure 2 Proportional to size allocation for each of the public health facilities in Hossana Town, 2014.

4.6 Study variable

4.6.1. Outcome (dependent) variable:

- ü Clients' satisfaction

4.6.2. Exposure (independent) variables:

- √ **Maternal Socio-demographic & Economic factors:** Age, marital status, residence, occupation, maternal educational status, ethnicity, religion and monthly income.
- √ **Experience of previous interaction**
 - ü Numbers of unintended pregnancy
 - ü Duration of using contraceptive
 - ü Degree of side effect
- √ Expectation
- √ Degree of knowledge
- √ **Health providers-related factors;**
 - ü Information given to clients
 - ü Technical competence
 - ü Interpersonal and Technical skills(Respect to client ,Privacy Confidentiality)
- √ **System-related factors;**
 - ü Facilities (waiting area, cleanness of room and toilets, Accessibility, Availability of supplies, drugs, and equipment)
 - ü Choice of methods
 - ü Appropriateness and acceptability of services(waiting time, working hours and days)

4.7. Data collection instrument and procedures.

4.7.1 Data collection instrument:

Quantitative Study

Structured questionnaire was adapted from different relevant literatures and modified to the local context. The questionnaire was prepared in English and then translated into Amharic and Hadiyyisa by those who are native to Amharic and Hadiyyisa language then back to English by other individual to ensure consistency, but finally administered in Hadiyyisa and

Amharic languages. The questionnaire was designed to obtain information on socio demographic characteristics of respondents and their satisfaction level with the different components of the family planning services which included the availability of supplies, information provision by the health workers, waiting time to get the services, and courtesy and respect of the health workers. The questionnaire consisted of five points Likert scale items, with 1 and 5 indicating the lowest and highest levels of satisfaction, respectively. The response categories for Likert scale items should have four or more categories to maximize variation. Level of satisfaction was indicated by selecting responses ranging from very dissatisfied=1, dissatisfied = 2, neutral=3, satisfied, =4 and very satisfied =5.

Qualitative Study

The focus group discussion was conducted among clients who didn't participate in the quantitative study in the same time period. Two health facilities were purposively selected to represent Hospital and HC services. Two focus group discussions were conducted in Hossana HC and two in Hospital. Each group had 7-8 participants of females. The principal investigator mediated the focus group discussions and the discussion of the participants was both audio taped and manually written by two other note takers. The focus group discussion within the different groups was carried out and analyzed thematically.

4.7.2 Data collectors:

Four clinical nurses who were working out of Hossana town and had experience in data collection were selected. One B.sc Nurse for supervision was recruited and participated in the study. Data collectors and the supervisor were trained for one day by the principal investigator on the study instrument, consent form, how to interview and data collection procedure.

4.7.3 Data processing and analysis:

Data was thoroughly coded, entered in to computer and cleaned carefully; missing values were handled not excluded in analysis by checking through data exploration before and was analyzed using SPSS 16.0 statistical software. Different frequency tables, graphs and descriptive summaries were used to describe the study variables. Bivariate logistic regression analysis was used to see significance of association between dependent and independent variables. All explanatory variables which had association in bivariate analysis with p value

less than 0.25 was entered in to multivariate logistic regression model in order to assess the independent predictors of satisfaction. P-value < 0.05 was considered as statistical significance in this study.

The qualitative data was also transcribed manually from the audio taped records and the notes taken. Results were analyzed manually written by summarizing the ideas forwarded by the participants.

4.7.4 DATA QUALITY CONTROL

Questionnaire was prepared first in English by the Investigator and then translated to Amharic and Hadiyyisa by other individuals who are native to Amharic and Hadiyyisa and had experience in translation. The questionnaire was translated back to English by another individual in order to maintain its consistency. Data was collected by trained data collectors and pretesting of the instrument was made before the actual data collection. Pre-test of the survey questionnaire among FP clients in Balesa town which was out of Hossana town in the zone to make sure clarity of the questionnaire and then necessary modifications and correction was made to ensure its validity. The internal consistency of the questionnaire was checked by computing Cronbach's alpha. Cronbach's Alpha was 0.89, 0.84, 0.81 and 0.76 for interpersonal, general cleanness, facility characteristics and technical aspects respectively. The selected and trained supervisor supervised the data collection on daily basis for completeness and consistency of the filled questionnaires

4.8 Ethical Consideration

Ethical clearance was obtained from ethical committee of Jimma University, College of Public Health and Medical Science. A formal letter, from the college of Public Health and medical sciences of Jimma University, was submitted to NEMMH, Hossana town health office and concerned bodies to obtain their co-operation. Then permission and support letter was written to each respective health facilities. The purpose of the study was explained to the study subjects at the time of data collection and verbal consent was secured from the participants to confirm whether they were willing to participate. The study subjects were informed that participation on voluntary basis. Confidentiality of responses was also ensured throughout the research process.

4.9 Dissemination plan

The findings of this study will be presented to JU, distributed to NEMMH, Hadiya Zone Health Department, Hossana town health office and other organizations working on related area. The findings may also be presented in different seminars, meetings and workshops. After the completion of the study properly, all effort will be made to publish the thesis in a reputable journal.

4.10 Operational definitions:

Waiting Time; - is the time clients had to wait before receiving their services. Acceptable waiting time: <30 min (26).

Accessible; those who lived less than 5Km or it takes less than 30 min to reach HF and waiting time<30min (30).

Interpersonal relations: the degree of empathy; trust/ rapport, confidentiality/ privacy maintained by provider to the client's needs.

Satisfaction: Attaining one's need or desire.

Very satisfactory: Above one's expectation.

Dissatisfactory: Below one's expectation.

Very dissatisfactory: Fail to meet one's expectation usually leading to disappointment (10)

Clients overall satisfaction level: was classified into high satisfaction score above cut point and low satisfaction below cut of point calculated using the demarcation threshold formula: $\{(total\ highest\ score - total\ lowest\ score) / 2\} + Total\ lowest\ score$ (41).

CHAPTER FIVE: RESULTS

The data were extracted from a total of 324 family planning users' in Hossana Town ; Public Health Facilities from February to March 2014 that makes the response rate 97.0% of which 73(22.5%) from Hospital, 98(30.2%) from Hossana HC and 72(22.2%) from Lichamba HC and 81(25%) from Bobicho health center. And four FGDs consist of 7-8 members which analyzed under four thematic areas. The results are presented under subheadings as follows;

5.1 Socio-demographic Characteristics

Out of the total 324 study subjects 236(72.8%) were repeat clients. The mean age of the mothers was 28 years ($SD\pm 5.57$) and ranges from 17 to 42 years. One hundred and fifteen (35.5%) of mothers were in the age range 25-29 years. Regarding the marital status, 4(1.2%) were single, 318 (98.1%) were married and 2(0.6%) were divorced. Regarding their religion, one hundred eighteen (57.7%) were protestant followed by orthodox 77(23.8%). The largest ethnic group was Hadiya 200(61.7%). Concerning the educational status of mothers 271(83.6%) had attended formal school out of which 131(40.4%) were grade 1-8, 74(22.8%) were secondary school and 66 (20.4%) were diploma and above.

Concerning employment status majority of respondents 265(81.8%) were unemployed and 182 (56.2%) house wife by occupation, only 59(18.2%) respondents were employed (table 1).

Table 1 distribution of respondents by their basic Socio demographic characteristics, Hossana Town, Southern Ethiopia, and February to March 2014

Socio-Demographic characteristics	Numbers	Percent	
Age group (n=324)	15-24	90	27.8
	25-29	115	35.5
	30-34	67	20.7
	35+	52	16.0
Marital Status (n=324)	Married	318	98.1
	Single	4	1.2
	Divorced	2	.6
Educational Status (n=324)	Illiterate	25	7.7
	can read and write	28	8.6
	primary cycle 1-4	48	14.8
	secondary cycle 5-8	83	25.6
	high school 9-12	74	22.8
Occupation (n=324)	diploma and above	66	20.4
	governmental	59	18.2
	employed		
	Merchant	66	20.4
	Farmer	3	.9
	house wife	182	56.2
Religion (n=324)	Others	14	4.3
	Orthodox	77	23.8
	Protestant	187	57.7
	Catholic	13	4.0
	Muslim	44	13.6
	Others	3	.9
Ethnicity(n=324)	Hadiya	200	61.7
	Kembata	33	10.2
	Gurage	30	9.3
	Silte	33	10.2
	Amhara	20	6.2
	Others	8	2.5
Residence	Urban	285	88.0
	Rural	39	12.0
Frequency of visit	New visit	88	27.2
	Repeat visit	236	72.8

5.2 Obstetrics and health service related variables

Study subjects were asked about their obstetrics and, 41 (12.7%) of them had abortion history 26 (8 %) of them had history of still birth. Concerning the information on choice of methods 305(94.1%) were received the method they wanted. Regarding the previous experience of interaction 68 (21%) of clients faced side on method they were used and 80(24.7%) had experience of unwanted pregnancy. Concerning information provision 243 (75%) of clients were informed on side effects of methods and 295 (91%) were told how to use the method and their function. Three hundred and one (92%) of clients reported that they were politely treated by the service providers and 271(83.6%) reported that their privacy was maintained. Two hundred eighty seven (88.6%) of clients said the way they were handled by supportive staffs was good. With regard to their opinion on waiting time 189 (58.3%) clients waited for less than 30 minutes to get the service, 106(32.7%) of them waited from 30 minutes to 1 hour and 29(9%) of them waited for more than 1 hour till they got the service. The mean waiting time was 26 minutes. Two hundred and sixty two (80.9%) of the clients said the waiting time was appropriate. Three hundred and nine (95.4%) reported that the opening hours in this clinic was convenient and 286 (88.3%) of clients said that it took them 30 minutes or less to reach the institution from their residence. Thirty eight (11.7%) clients took more than 30 minutes (table 2).

Table 2: Distribution of respondents by obstetrics and health service related variables in Hossana Town, Southern Ethiopia, and February to March 2014

Variables	Category	Number	Percent
you received the method you wanted	Yes	305	94.1
	No	19	5.9
Have you history of face side effect on method	Yes	68	21.0
	No	256	79.0
Have you History of shifting method	Yes	128	39.5
	No	196	60.5
Have you history of unintended pregnancy	Yes	80	24.7
	No	244	75.3
Numbers of unwanted pregnancy	Once	55	17.0
	twice	28	8.6
	and above		
Were you told how to use the method	Yes	295	91.0
	No	29	9.0
Were you told about the method's side effects	Yes	243	75.0
	No	81	25.0
Did the provider tell you to return if you have problems	Yes	215	66.4
	No	109	33.6
were you treated with respect and courtesy at the reception desk	Yes	287	88.6
	No	37	11.4
you are treated with respect and courtesy by the care provider	Yes	301	92.9
	No	23	7.1
your privacy was respected when you were asked to share sensitive issue	Yes	271	83.6
	No	53	16.4
Did you have enough privacy during exams and procedures	Yes	273	84.3
	No	51	15.7
the hours this clinic is open convenient for you	Yes	309	95.4
	No	15	4.6
the working hours of the clinic delay from getting service	Yes	72	22.2
	No	252	77.8
health facility was clean	Yes	308	95.1
	No	16	4.9
waiting time was long	Yes	62	19.1
	No	262	80.9

The assessment of women's overall components in the family planning services indicated that 244(75.3%) were satisfied and 80(24.7%) were not satisfied. Table 3 shows the results of women's satisfaction with the different components in the family planning services regarding informed choice of family planning method and service provider's interpersonal skills. Concerning the information given to clients, two hundred and thirty eight (73.5%) of women

had high satisfaction (completely satisfied and satisfied) with information they received about the use of their chosen FP method and 307 (94.8%) were completely satisfied or satisfied because the information Service providers gave them opportunity to take part in decisions on FP methods choice. Ninety five (29.3) of clients were not satisfied on explanation about procedures. Concerning provider interpersonal relationship, 299 (92.3%) of women reported that Service providers were respectful (completely satisfied or satisfied) and 291 (89.6%) of clients were trusted by the service providers (completely satisfied or satisfied). Two hundred ninety nine women (92.3%) had high satisfaction with cooperation of providers and 307 (94.7%) were completely satisfied or satisfied with the mutual understanding between service providers and them.

Regarding appropriateness and acceptability of services, 308 (95.1%) women were satisfied (completely satisfied or satisfied) with Cleanliness of health facilities and 279 (86.1%) women were completely satisfied or satisfied with comfortable waiting room (had enough sitting chairs).

There were 266 (82.1%) of women were completely satisfied or satisfied with waiting time to get service and 274(85.6%) were completely satisfied or satisfied with Working hours of health facilities (table 3).

Table 3 Level of satisfaction of clients with the different components in the family planning services of the Hossana Town, and February to March 2014 (n = 324)

Characteristics	1	2	3	4	5
	No.(%)	No. (%)	No. (%)	No. (%)	No. (%)
Service providers were respectful	0(0)	6(1.8)	19(5.86)	148(45.7)	151(46.6)
Service providers have shown concern	0(0)	3(0.9)	27(8.3)	125(38.6)	169(52.2)
Service providers have shown Comfort	0(0)	5 (1.5)	27(8.3)	140(43.2)	152(46.9)
Mutual understanding between service providers and you	0(0)	4(1.2)	13(4)	152(46.9)	155(47.8)
Trust with service providers	0(0)	13(4)	20(6.2)	145(44.8)	146(44.8)
The provider was cooperative	0(0)	9(2.8)	16(4.9)	150(46.3)	149(46)
Service providers gave opportunity to take part in decisions	0(0)	8(2.5)	9(2.8)	127(39.2)	180(55.6)
Service providers gave adequate information	0(0)	37(11.4)	49(15.1)	139(42.9)	99(30.6)
Service providers explanation was clear and straightforward	0(0)	15(4.6)	13(4.0)	168(51.9)	128(39.5)
Service providers explained procedures	1(0.3)	40(12.3)	54(16.7)	131(40.4)	98(30.2)
Cleanliness of clinic	1(0.3)	8(2.5)	7(2.2)	145 (44.8)	163 (50.3)
waiting room has enough sitting chairs	0(0)	27 (8.3)	18 (5.6)	125 (38.6)	154 (47.5)
Attractiveness of clinic	1(0.3)	15 (4.6)	10 (3.1)	134 (41.4)	164 (50.6)
waiting room ventilation	0(0)	12 (3.7)	8 (2.5)	125 (38.6)	179 (55.2)
Location of clinic	0(0)	3 (0.9)	11 (3.4)	151 (46.6)	159 (49.1)
Waiting time to get service	0(0)	49 (15.1)	9 (2.8)	129 (39.8)	137 (42.3)
Waiting time at clinic	0(0)	47 (14.5)	14 (4.3)	135 (41.7)	128 (39.5)
Working hours of clinic	0(0)	37 (11.4)	13 (4.0)	157 (48.5)	117 (36.1)
Overall level of Satisfaction	0(0)	7 (2.2)	20 (6.2)	173 (53.4)	124 (38.3)

Very dissatisfied (1), dissatisfied (2), neither/ nor (3), somewhat satisfied (4) and Very satisfied (5)

Regarding the level of satisfaction in four different categories, namely accessibility of the health services, Interpersonal component and Cleanness of health facilities, this study showed

that majority of were satisfied on Cleanness of health facilities (88.3%) but less satisfied with technical aspect of health providers (70.1%)

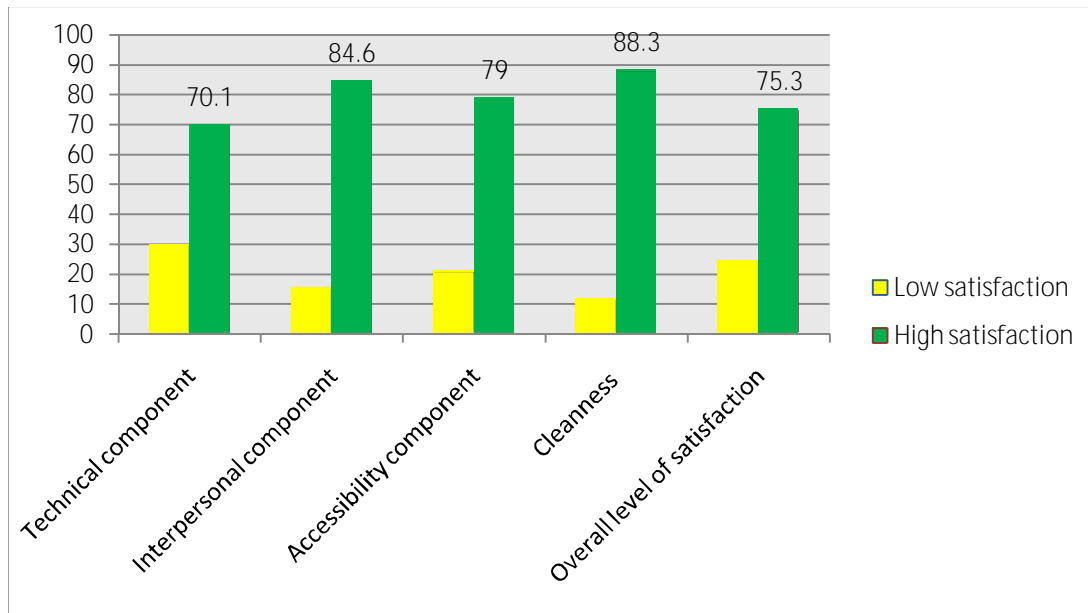


Figure 3 Level of Satisfaction with family planning services based on Four Dimensions, in Hossana Town, Southern Ethiopia, February to March 2014

5.3. Factors affecting clients' satisfaction with family planning services

5.3.1. Socio-demographic variables

Family planning service satisfaction was assessed for its association with socio-demographic variables. Bivariate analysis in the binary logistic regression model showed that age of clients, maternal educational level and numbers of living children were significantly associated with family planning service satisfaction at p -value < 0.05 . The result showed that older age groups 35-49 were 2.6 times more satisfied than younger age group 15-24 of mothers (COR= 2.62 [95%CI= 1.10, 6.263]). Mothers with educational status who can read and write without attending formal education 3.9 times were more satisfied than mothers with educational status of collage level and above (COR=3.89 [95%CI=1.10, 14.34]) and mothers with number of living children 5 and above were 2.5 times more satisfied than mothers with numbers of living children 4 and below (COR=2.52 [95%CI=1.19, 5.34]). In this study, respondents who utilized services at Hossana and Lichamba health centers were 61.3% and 60.7% respectively less likely to be satisfied with services as compared to the respondents from Hospital. Other variables like occupation of mothers, resident, religion, marital status and ethnicity were not significant in bivariate analysis at p -value < 0.05 (table-5).

But the multivariable analysis, adjusting possible confounding variables, from Sociodemographic variables none of them were statistically significant with satisfaction in the multivariate analysis

Table 4: Comparison of satisfaction of client with their socio-economic characteristics of

Family planning attendants, in Hossana Town, Southern Ethiopia, and February to March 2014

Satisfaction level			Low satisfaction No. (%)	High satisfaction No. (%)	COR (95%CI)	AOR (95%CI)
Age of mother	15-24		29(32.2%)	61(67.8%)	1	1
	25-29		29(25.2%)	86(74.8%)	1.41[0.77, 2.60]	1.12 [0.46, 2.68]
	30-34		14(20.9%)	53(79.1%)	1.80 [0.86, 3.76]	2.74 [0.748, 10.03]
	35-49		8 (15.4%)	44(84.6%)	2.62[1.10, 6.26]*	1.12 [0.16, 7.81]
Educational status of mother	Illiterate		4(16%)	21(84%)	2.45[0.75,6.85]	1.25[0.23,6.85]
	Read and write		3(10.7%)	25(89.3%)	3.90[1.10,14.34]*	2.82[0.40,19.71]
	Primary		26(19.8%)	105(80.2%)	1.89 [0.962,3.70]	1.23[0.43,3.55]
	Secondary		26(35.2%)	48(64.8%)	0.86 [0.43,1.74]	0.87[0.34,2.24]
	Collage and above		21(31.8%)	45(68.2%)	1	1
Names of health facilities	NEMMH Hossana		12(16.4%)	61(83.6%)	1	1
	HC		33(33.7%)	65(66.3%)	0.387[0.18 ,.82]*	0.35[0.124, 9.87]
	Lichamba		24(33.3%)	48(66.7%)	0.393[.18,.87]*	0.364[0.121,1.10]
	Bobicho		11(13.6%)	70(84.6%)	1.25[0.52,3.04]	0.540[0.152,1.92]

*=p-value<0.05, **=p-value <0.01, ***=p-value<0.001

5.3.2. *Obstetrics and health service related variables*

Family planning service satisfaction was assessed for its association with obstetrics and health

Service related variables. Bivariate analysis in the binary logistic regression model showed that from obstetric variables; frequency of family planning visit and parity were statistically associated with satisfaction with family planning service at p-value < 0.05. On the other hand history of abortion and still birth were not statistically associated with satisfaction with family planning service at bivariate logistic regression analysis (table 6).

In the multivariable analysis, cleanness of health facility, waiting time to get services, frequency of visit, experience of unintended pregnancy, history of side effect with methods, history of methods shift, convenience of the hours when clinic is opened, privacy during examination and procedures, told how to use the method and written information on side effects were predictors of satisfaction with family planning.

Repeated visitors were 3 times more satisfied as compared to those who were new visitors (AOR=3.04[1.37, 6.74]) and those who had experience on contraceptive methods side effect were 72% less satisfied than who had no experience on methods (AOR=0.280 [95%CI= [0.121, 0.645] was significantly associated with family planning service satisfaction. The findings of this study revealed that clients who had history of unintended pregnancy were 2.8 times more satisfied as compared with those who had no experience (AOR=2.803[1.058, 7.426]) (table 6). Clients who were told how to use the method were 3.43 times more satisfied with services than those who were not told (AOR=3.43 [95%CI=1.206, 9.761]). Mothers whose privacy was ensured during exams and procedures were 5.08 times more likely satisfied than those who reported privacy was not ensured (AOR=5.08 [95%CI=2.270, 11.387]) (table 8). Clients who get service with in 30 minute were 5.5 times more satisfied as compared to those who get after more than 60 minute (AOR=5.5 [95%CI=1.918, 15.77]) and clients who reported the opening hours of clinic was convenient were 4.7 times more satisfied than those told the opening hours of clinic was not convenient (AOR=4.73[1.22,18.38]) . Clients who perceived health facilities was not clean were 81% less satisfied as compared to those who perceived clean (AOR=0.192[0.056, 0.658]) (table 6-7). But still birth, travel time, expectation with services, parity, politeness of provider were not statistically significant factors of satisfaction with family planning services in the multivariable logistic regression analysis (Table 6-7)

Table 5: Comparison of satisfaction of client with their obstetric and experience of previous interaction and health facility related variables among Family planning attendants, in Hossana Town, Southern Ethiopia, and February to March 2014

Variables		Satisfaction level		COR (95% CI)	AOR (95% CI)
		Low satisfaction No. (%)	High satisfaction No. (%)		
Parity	0-4	61(28.4)	154(71.6)	0.49[0.25,0.96]*	.342 [0.051, 2.28]
	>4	12(15.6)	65(84.4)	1	1
Still Birth	Yes	3(11.5)	23(88.5)	2.67[0.78, 9.15]	2.11[0.33, 13.48]
	No	77(25.3)	221(74.7)	1	1
No. livening children	0-4	71(27.7)	185(72.3)	0.40[0.19, 0.84]*	0.384[0.125, 1.18]
	>4	9(13.2)	59(86.7)	1	1
Current F/P visit	New	29(33)	59(67)	1	1
	Repeat	51(21.6)	185(78.4)	1.78[1.04,3.05]*	3.04[1.37, 6.74]**
History of unintended pregnancy	Yes	9(11.3)	71(88.7)	3.24[1.5, 6.8]**	2.8[1.1,7.43]*
	No	71(29)	173(71)	1	1
History of faced side effect	Yes	29(42.6)	39(57.4)	0.34[0.19, .59]*	0.28[0.121,0.645]*
	No	51(20)	205(80)	1	1
waiting time	0-30	28(14.8)	161(85.2%)	3.51[1.5,8.27]**	5.50[1.92, 15.77]**
	31-60	41(38.7%)	25(60%)	0.97[0.416, 2.257]	1.82[0.64, 5.22].
	>60	11(38%)	2(66.7%)	1	1
convenient opening hours of clinic	Yes	70(22.7%)	239(77.3%)	6.8[2.26,20.64]**	4.7[1.22,18.38]*
	No	10(66.7%)	5(33.3%)	1	1
cleanness of HF	Yes	71(23%)	237(77%)	1	1
	No	9(56.3%)	7(43.7%)	0.23[0.09, 0.65]**	0.19[0.06, 0.66]**

*=p-value<0.05, **=p-value <0.01, ***=p-value<0.001

Table 6; shows Comparison of satisfaction of client with their health provider related variables in Hossana Town, Southern Ethiopia, and February to March 2014

Variables	Satisfaction level				
		Low satisfaction No. (%)	High satisfaction No. (%)	COR (95%CI)	AOR (95%CI)
enough privacy was ensured during exams and procedures	Yes	49(18)	224(82)	7.1[3.7,13.4]**	5.1[2.3,11.3]***
	No	31(60.8)	20(39.2)	1	1
privacy respected when you were shared sensitive issue	Yes	51(19)	220(81)	5.2[2.80,9.70]*	0.99[0.25, 3.86]
	No	29(54.7)	24(45.3)	1	1
registration staff treated with respect and courtesy	Yes	63(22)	224(78)	3.0[1.49,6.13]*	0.60[0.16, 2.28]
	No	17(46)	20(54)	1	1
care provider treated with respect and courtesy	Yes	66(22)	235(78)	5.54[2.3,13.4]*	1.77[0.34, 9.15]
	No	14(60.9)	9(39.1)	1	1
gave written information on side effects	Yes	14(13.2)	92(86.8)	2.85[1.52,5.4]*	1.82[0.71, 4.64]
	No	66(30.3)	152(69.7)	1	1
told about the method's side effects	Yes	55(22.6)	188(77.4)	1.53[0.87, 2.67]	0.75[0.30, 1.89]
	No	25(30.9)	56(69.1)	1	1
told about how to use the method and function	Yes	66(22.4)	229(77.6)	3.238[1.5, 7.1]*	3.43[1.2,9.76]*
	No	14(48.3)	15(51.7)	1	1

*= p-value <0.02, **=p-value<0.01, ***=p-value<0.001

Qualitative Result

Focus Group Discussion

A total of 30 female Family planning clients participated in four Focus group discussions.

The two focus group discussions were conducted in Hossana HC and two in Hospital purposive.

Theme-1 supplies of logistics

Most of clients said that there were enough choice of family planning services in the health facilities and no problems in supply of methods .But a 29 years old said “*some health providers enforce to use long term methods and didn’t want to remove when we asked to remove it, in place they appointed for other day*”. Other discussant supported her idea “*...there was no enough equipment in health facility...*”

Theme-2 Interpersonal skills

Regarding courtesy and respect by health workers and the registration room workers many discussants explained that they were happy by the good courtesy and respect of the health workers. However, one discussant from HC said “*there is still a little problem in respecting clients by some health providers and registration room workers*”. Other discussants told “*I am very happy because most health providers are cooperative and good in courtesy and respect even though there is problems rarely*”. Regarding time spent and completeness of the physical examination and privacy by the health workers most of the participants reported that physical examination in most of the times is done in a better way than the previous times. One of them contradicted this idea and said “*...there is no privacy in the examination rooms; doors are frequently opened while clients are on examination...*”

Theme-3 Information provision to clients

Most discussants said the existing method/s used in the hospitals to provide information to clients about the services and their health problems was reported well in general. However, one of the discussant explained, “*the method of information provision used has a problem and thus I were looking for and going around repeatedly getting the room when I were new for this service*”. Other discussant strengthening this idea said “*this is also true for those who can’t read and new for service*”.

A 36 years old mother said “*it is generally good but need some modification on method of information provision for the new and illiterate clients visiting the hospitals and health center*”. Most discussants shared her idea.

Theme -4 Factors contribute to dissatisfaction and suggestion to improve

When clients were asked to explore major factors that contribute to the dissatisfaction most discussants reported that long waiting time and delay in starting work during morning were major factors that lead to dissatisfaction. Another discussant expressed her feeling “*inadequate information about the services and their health problems was cause dissatisfaction*”. Most of the discussants shared this idea.

Some of them explained dissatisfaction of clients also results from inadequate and unclean latrines and long waiting time to get the services in the hospitals.

When clients were also asked suggestion to improve the services in FP of the health facilities, most discussants told adequate information on methods and services. One discussant said “...*should be recruited better skillful health providers as important measures*”. One discussant told “*most of the time providers said the equipment was not prepared for long methods users as a reason not to remove it. Therefore, health facility should supply enough equipment and better methods that not cause problem for health*”.

CHAPTER SIX: DISCUSSION

Clients' satisfaction is the key indicator that can reflect the health service quality at any level of health care facilities. Therefore measuring clients' satisfaction is a useful method to evaluate quality of services.

One hundred and fifteen 35.5% of mothers were in the age range 25-29 years and 83.7% attended formal education which is lower than studies done in Addis Ababa private hospitals which was 93.2% (40) but higher than study in Bahar-dar where it was 61.8% (5). This variation might be time gap in year of studies and difference in proportion of educated women in city and town. The occupational status of most of the clients in this study was housewife 56.2% followed by merchant 20.4 %.

This study showed that about three fourth of the clients were satisfied with the service they had received (75.3%). This level of satisfaction was nearly similar to studies conducted in the JUSH which was 77.0 % (10), higher than 68% reported from Bangladesh (22) and lower than 93.7% reported from Jimma zone (26). The report from Bangladesh showed 39% highly satisfied, 47% moderately satisfied, and 14% with low level satisfaction (30) and a study in Thailand (7) showed 23.3% highly satisfied, 61.4% moderately satisfied and 15.3% were lowly satisfied. The variations might be attributed to differences in facilities, working culture and clients' flow. The better satisfaction level (75.3%) in this study could possibly be explained by the fact that higher proportion of mothers was repeated users and this in turn might indicate the service is well to expectation of the clients.

Three hundred and five 94.1% of women choose the contraceptive by themselves but only 5.9% were influenced by service providers. Significant numbers (33.6%) of the clients were not provided information about the health services and their health problems. This is quite higher when compared to the study conducted in FP service delivery points in Bahar-dar town with a 25.2% dissatisfaction rate (5). This might be due to the difference in study period.

Visual privacy was maintained for 84.3% of clients and this is in line with 83% reported from Kenyan survey (38) but is lower than 97.3 % from Addis Ababa (40). The difference might be attributed to the fact that difference in health facilities structure that helps to maintain privacy in Addis Ababa. This result is supported by qualitative result as other discussants said *"I am very happy because most health providers are cooperative and good in courtesy and respect even though there is problems rarely"*. Aural privacy in this study is 83.3% which is

higher than study conducted in Kenya which was 75% (37). Most women (93%) were satisfied that the behavior of the service provider was polite. This study is similar with study in Uremia which was 92.5% (35).

Highest satisfaction rate (92.3 %) was with the courtesy of the health care providers.

This is nearly a similar finding when compared with the finding of the study conducted in Bahar-dar town which showed 84.4% satisfaction rate on good provider greeting and respect in the governmental family planning service delivery points including the hospital (5).

The long waiting time for clients before getting service is one of the factors affecting client satisfaction resulting in negative association with it. In this study, 58.3% of the clients get service within 30 minutes but 14.5% of clients waited for more than one hour which is higher than a study report from Jimma Zone (33). Two hundred sixty two (80.9%) of clients reported that waiting time to get services was appropriate. This study is nearly consistent with a study in Addis Ababa (40) where about one fourth of clients claimed that the waiting time for service was very long. The mean waiting time was 26 minute and 30 second with maximum and minimum 90 and 4 minutes respectively. As to this study, 19.1% of the clients told overall waiting time to get the services was long. This finding is lower than study in JUSH that showed 37.2% of clients not satisfied (10) and study in Bangladesh (30) 52.6% had to wait for longer time to get the service. The variation can be because of difference in facilities and clients flow. Two hundred and seventy nine 86.1% of the respondents told the availability of the waiting place with enough sitting chairs. This finding is also higher than study in Bangladesh 26.3% respondents told the availability of the waiting place were enough (30). Possible reason for this difference might be different in numbers of clients and proportion of health facilities between two countries.

Three hundred and nine 95.3% of clients were satisfied with the length of time that the facilities were open to the public. This finding is comparable with result of study in Australia 98% (23) but higher than study conducted rural Bangladesh 65.8% (22).

This study showed that clients in 15-24 age were less satisfied (67.8%) than those in age 35-49 (84.6%) the difference was statistically significant in bivariate regression but not in multivariate at p-value <0.05. This result is consistent with the finding from Jimma zone where age was not significant (26). But finding from Hawassa University Referral Hospital age was significantly associated with satisfaction (34).

Based on level of education, this study found that clients with educational status who can read and write without attending formal education were more satisfied (89.3%) than mothers

with educational status of collage level and above (68.2%). As educational level of the client's increases, client satisfaction decreases. The difference was statistically significant in bivariate regression at p-value <0.05. This finding is in line with study in Bangladesh (30), Eastern Saudi Arabia (28) and study in Ghana (32) where mothers with at least secondary education are more likely to be dissatisfied.

In this study, respondents who utilized services at health centers were less likely to be satisfied with services as compared to the respondents from hospital. Possible reason might be clients who utilized service at hospital were got what they expected. In our study waiting time was significantly associated with client satisfaction .This finding is consist with that reported from study in JUSH (10) and rural Bangladesh (22) but inconsistent with other study in Jimma zone (26). Clients who perceive a health facility was not clean were 81% less satisfied as compared to those who said facility was clean. This finding is consistent with the finding in Kenya, Ghana and Tanzania (11) that reported cleanliness of the facility was significantly associated with client satisfaction.

More than three forth of (78.4%) repeated users were satisfied as compared with 67% satisfaction rate amongst new users and the difference was significant. This finding is consistent reported from Saudi Arabia where frequency of visit was significant (28). Possible reason more satisfaction in repeat visitors could be enhanced awareness on service and they were already satisfied.

Side effect of method is one of the factors that affect women's satisfaction with family planning services. Women who had faced side effects of methods were 28% less likely to be satisfied as compared to those who were not affected by side effects and the difference was statistically significant at p-value <0.05. It negatively affects satisfaction of clients with services. This is a similar finding with that of the study conducted in Iran (30).Suggested reason for less satisfied on those clients was inadequate information on side effect and alternative choice of methods

Experience on unintended pregnancy was one of the predictors in this study. Clients who had history of unintended pregnancy were 2.8 times more likely satisfied with services as compared to those who had no that experience and the difference is statistically significant. This is consistent with the finding in Iran (30). Possible reason more satisfaction on those clients who had history of unintended pregnancy expectation was met since no unintended pregnancy occurred after using service

Information on how to use method was predictor of satisfaction in this study. Clients who were told how to use the method were 3.43 times more likely to be satisfied with services as compared to those who were not told and the difference was statistically significant. This finding is consistent with that reported from Kenya (37) and it clearly underlines that the service providers should take their time to properly and adequately explain how to use the methods to their clients.

Regarding the level of satisfaction in different four categories, namely accessibility of the health services, Interpersonal component and Cleanliness of health facilities, this study showed that majority were satisfied on Cleanliness of health facilities (88.3%) but less satisfied with technical aspect of health providers (70.1%). This showed that clients were concerned about the technical aspect of providers that these were not enough and they need to improve. This result is supported by qualitative result as one discussant said “...*should be recruited better skillful health providers as important measures*”

The major causes of dissatisfaction forwarded by clients were long waiting time (19.1%), inconvenient opening hours of clinic (15.7%) and inadequate information (26.5%). This finding is supported by qualitative study. As one discussant said “*inadequate information about the services and their health problems was cause dissatisfaction*”.

Strength of study

The study employed well structured questionnaire with five point Likert scale and reliable tools for measurement of satisfaction.

The study was supplemented by qualitative methods of data collections (FGD) which was very helpful in finding out the details of the problems.

There is lack of adequate literatures in our country; this study has identified the level of satisfaction with family planning service in Hossana town and this study would be an input in this regard.

Limitation of study

It may not be appropriate to assess the level of satisfaction of each service by applying scale of measurement.

Providers might also show the best behavior responses during client-provider interaction and perhaps users might also show courtesy bias during the exit interview.

CHAPTER SEVEN: CONCLUSION AND RECOMMENDATIONS

7.1 Conclusion

Quality is rapidly becoming a global issue and of concern to both the providers and the users of health care services. Also, the issue of client satisfaction and dissatisfaction has become a topic of increasing importance in health care.

Generally, most of the clients were satisfied with the service that they had received.

According to the four dimensions, the result showed that most of the clients were satisfied with interpersonal aspects from the staff and cleanness of health facilities. However, the clients were less satisfied with the technical aspect and accessibility.

The frequency of visit, waiting time, cleanness of health facilities, history of side effect, history of unintended pregnancy, and information on how to use methods, privacy during examination and procedure and convenience of opening hour were the final predictors of client satisfaction in this study. The finding of qualitative study support major findings of qualitative study.

7.2 Recommendations

Based on the study findings the following recommendations are forwarded.

Improving the waiting time should be considered by the hospital and Health centers management to improve the level of clients' satisfaction with services.

Hospital and Health Centers management should consider opening hour of clinic according to recommended by Government.

Health providers should provide adequate information and proper handling of clients in particular for new clients.

Health care workers should provide adequate information on side effects of methods; explain how to use the methods.

Health providers and health facilities should prepare ready enough equipment for clients.

Further studies that mainly address all areas of associated factors (quality of services in all dimensions) that may significantly affect satisfaction are needed.

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Annex I: English version questionnaires

Questionnaire for data collection on the assessment of the level of client satisfaction with the family planning services in Hossana Town health facilities.

Institution code No -----

Verbal Consent Form before Conducting the Interview

Greetings:

Hello, how are you?

My name is ----- . I am currently a student in Jimma University, Department of Nursing and Midwifery, who is now going to conduct a survey. I would like to interview you few questions about the family planning service provision of health facilities. The objective of the study is to assess the level of clients' satisfaction with family planning services of the Health facilities and to identify the factors affecting the satisfaction of clients in Hossana Town health facilities, which will be important to improve the health service delivery. Your cooperation and willingness for the interview is very helpful in identifying the problems related to this issue. Your name will not be written in the form and I assure you that all information that you give will be kept strictly confidential. Your participation is voluntary and you are not obliged to answer any question you do not wish to answer. If you are not still comfortable with the interview, please feel free to stop it any time you like. Do I have your permission to continue?

1 – If yes, continue to the next page

2 – If no, skip to the other participant

Interviewer's name -----, signature-----

Date of interview-----, Time started _____, Time finished -----

-

Supervisor's name -----, Signature -----

I thank you for your cooperation

PART ONE: SOCIO – DEMOGRAPHIC CHARACTERISTICS

S.N	QUESTIONS	RESPONSE	CODE
101	Age (in years)		
102	Marital Status	1- Single 2 –Married 3 –Divorced 4 –Widowed	
103	Do you have children?	1.Yes 2.No	
104	If yes, how many living children do you have?		
105	Educational Status	1. Illiterate 2. Can read and write 3.primary cycle (1-4) 4.secondary cycle (5-8) 5.high school (9-12) 6.Diploma and Above	
106	Occupation	1 –Governmental employee 2 – Merchant 3 – Farmer 4 – House wife 5 – Other (specify).....	
107	What is your religion	1. Orthodox Christian 2. Protestant 3. Catholic 4.Muslim 5.Other (Specify)-----	
108	What is your ethnicity?	1. Hadiya 2. Kembata 3. Gurage 4.Silte 5.Amhara 6.Other (specify)----	
109	What is your monthly income? Eth.birr	

110	What is your Residence?	1. Urban	2. Rural	
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II. Obstetric profile and current health status			Yes	No
201	Parity			
202	Abortion			
203	Still Birth			
204	Current F/P visit	1. new 2. repeat		

III. Questions for assessing Client about F/P methods				Remark
301	Which of the following methods do you know?	1. Pills 2. Injectable Implants 4. Diaphragm	5. IUCD 6. Condom 3 8. Other (specify)-----	
302	Where do you get the information?	1. Health professional 2. Peer/Neighbors 3. Media		
303	What is/are the advantage/s of modern contraceptive?	1. Prevention of unwanted pregnancy 2. Child spacing 3. Medication 4. Prevention of STDs 5. Regulation of menstrual cycle 6. Others, specify		
304	Did you receive the method you wanted?	1. Yes 2. No		If yes, skip to Q305
304.1	If your answer for Q 304 is NO, why?	1. Your choice of method is not available 2. Provider chose for you 3. Contraindication for method wanted 4. Pregnancy suspected 5. Others ,specify		
305	Have you History of shifting from one to other F/P method?	1. Yes 2. No		If No Skip to Q306

306	Have you history of face side effect on method you were used?	1. Yes 2. No	
307	For how long were used contraceptive?	-----	
308	Have you history of unintended pregnancy?	1 yes 2 no	If no skip to Q 309
309	If yes ,how many times	-----	

Information about contraceptive methods		Yes	No
310	Were you told how to use the method and its function?		
311	Were you told about the method's side effects?		
312	Were you given written information on side effects of the method?		
313	Did the provider tell you to return to the clinic if you have problems with the method?		
314	When you arrived at the clinic, were you treated with respect and courtesy at the reception desk?		
315	Do you believe that you are treated with respect and courtesy by the care provider?		
316	Do you think that your privacy was respected when you were asked to share sensitive information?		
317	Did you have enough privacy during exams and procedures with the service provider?		
Appropriateness and acceptability of services			
318	Are the hours this clinic is open convenient for you? (If yes, Skip to 315)	Yes	No
319	If your answer is No, what time would be most convenient to you?	1. Earlier in the morning 2. Over lunch hour 3. Afternoon 4. Weekends/holidays 5. Other.....	
320	What is the average waiting time to get service from the F/P clinic?		
321	How do you evaluate the length of this waiting time?	1.too short 2 .appropriate 3.too long	
322	How long did it take you to get here today? (in minutes)		
323	Did the working hours of the clinic delay you from getting service?	yes	No

324	Was this health facility Clean		
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Part IV Service expectation

Before utilizing the services, what was your expectation towards the following issues?		Very poor	Poor	No expectation	Good	Very good
401	Cleanliness of health facilities					
402	Enough space in waiting room					
403	Provider respectful and treats me with dignity					
404	Supply of methods					
405	Provider clear and easy to understand my health condition					
406	Cost of the service					
407	Waiting time to get service					
V. Satisfaction question		Very Dissatisfied	dissatisfied	Neither/nor	Somewhat satisfied	Fully satisfied
	Interpersonal skill	1	2	3	4	5
501	Service providers were respectful.					
502	Service providers have shown concern					
503	Service providers have shown Comfort					
504	Mutual understanding between service providers and you					
505	Do you trust the service providers					
506	The provider was cooperative					
507	Service providers gave opportunity to take part in decisions concerning choice of methods					
Technical aspects						
508	Service providers gave adequate					

	information					
509	Service providers explanation was clear and straightforward					
510	Service providers explained procedures					
	Physical environment					
511	Cleanliness of clinic					
512	waiting room has enough sitting chairs					
513	Attractiveness of clinic (privacy...)					
514	waiting room ventilation					
	Organization of health care					
515	Location of clinic(access)					
516	Waiting time to get service					
517	Waiting time at clinic					
518	Working hours of clinic					
519	How do you rate your overall level of Satisfaction regarding the delivery of the health service you received?					
520	Will you come back for next appointment?					

Interview guide for Focus Group Discussion on FP clients of public health facilities

1. How is the courtesy and respect by the health workers and the registration room workers?
2. Can you please tell me about the provision of information of the services of the FP (e.g., in locating rooms for registration, examination rooms, lab. And drug dispensing)
3. Would you please tell me about the time spent and completeness of the physical examination and privacy by the health workers?
4. Please tell us about the laboratory service in this health facility
5. What about availability of drugs and other supplies?
6. What are the major factors that you think contribute to the dissatisfaction of clients?
7. What is your suggestion in order to improve the services in FP of the health facilities?

Annex II: Questionnaire Amharic version

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101		-----
102		1. 2. 3. 4.
103		1. 2.
104		-----
105		1. / 2. 3. 4. 5. /
106		1 2. 3. 4. 5.
107		1. 2. 3. 4.
108		1. 2. 3. 4. 5. 6.
109		-----
110		1. 2.

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201.		-----
202.		1. 2.
203		1. 2.
204		1. 2.

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301		1. 2. 3. 4. 5. 6. 7.	
302		1. 2. / 3. 4.	
303		1. 2. 3. 4. 5. 6.	
304		1. 2.	. 305
305		1. 2. 3. 4. 4. .	
306		1. 2.	. 306

307		1. 2.	
308		-----	
309		1. 2.	
310		-----	
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320		1. 2. 3. 4. 5.	
321		-----	
322		1. 2. 3.	
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324		1. 2.	

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Annex III: Questionnaire Hadiyisa version (local language)

Baxanchi matto:-minaadaph heechch ogoraa gat qaanquwwa

Xigo	Xamichchuwa	Dabachchuwa	
101	Umer mee'o (hundem hincho)	_____	
102	Min issaqim ogori	Agisumoyyo _____1 Agisamoo _____2 Anani ihamoo_____3 Min ani lehako_____4 Mulleka(caakise)_____5	
103	Kiina ciilluw yoo	1. ooyya 2. Aa'ee	
104	Yoolas mee'o		
106	Mee'i baxxancha gulitta?	1. Lossan bee'e 2. Qananaa immaa kitaabimma xanoommo 3. 1-4 affabee 4 5-8 affabee 5 9-10 affabee 6 11-12 affeebe'e 7 Dipholomii hanane 8 Mulane (caakise)	
107	Baxxi ogori maha?	Adi'l batancho_____1 Daddaraanch_____2 Abuulaancho _____3 Mi'in ama _____4 Mullane (caakise)_____99	
108	Kaba yoo baxi ogori maha?	Adi'l baxanicho_____1 NGO baxanicho_____2 Gilli secte'l baxancho_____3 Dadarancho _____4 Mine baxo(menticho)_____5 Bali baxancho _____6 Losancho _____7 Bax bee'ane _____8 Mulane(caakise)_____99	
108	Amanati maha?	Potestanta _____1 Oritodoqisa _____2 Musilima _____3 Katolika _____4 Mulane(chakise)_____99	

109	Ki shumo'i maha	1. Hadiyya 2. Kambaata 3. Guraage'e 4. Silxe'e 5. Amaara 6. Mullane (caakise)_____	
110	Ki mine lambe'anch siixo'i mee'o (Meeda'e xige kuro xamme)	_____ La'oommoyo _____77	
111	Mee'aa awoontaate	1. Mataare 2. Lamii hanaan	
112	Ki heech beyyi hinke'e	Beero'o _____1 Haxihulla _____2	

Baxxanch II kaba yoo xummii qach ogora			Ooyya	Aa'ee
201	Mee'aa qattaa			
202	Keemmoo qach ogora			Aa'ee xa'mmich 203
202.1	Godabo aphixximma			
202.2	Lehaa qaaraama			
203	Kaba watti abaroos qood mee'o	Luxxane la'mmane saxxne soorii hannaane		

Baxxanch III. abaroos qoodimmi bikkina yoo xammicha			Mare
301	Hinika hinikaa abaroos qoodimmi bikkina hagara laqoo?	1. kiniina dubakammane (IUCD) 2. marfe 3. 4. Daaphragma	5. Ka'ill girgida 6. Condoma 7. Cekko dubakkamane 8. mullene(caakise)----
302		7. Hasakam bee'i lamfoolano 8. Qeessaka qarimmina 9. qaraaroomina 10. sha'ixxi eddanch jabbina 11. aga'n xura egerimmina 12. mulleka, (caakkise)	
303	Hannone maccessitto?	4. Xumma egeraani 5. Beshii/olla'ii	

		6. Rado'ii te'im telibejina 7. Mullane(caakise)-----	
304	Hassi abaroos qoodimmi ogora siiddaa?	Ooyya Aa'ee	ooyyaihul as305hige
305	Ka illageen abaroos qoodimmi ogora dabassitaa?	3. ooyya 4. aa'ee	Dabach aa'ee ihulas xammich Q306
306	Hinkaa'n ammane abaroos qoodimmi ogora awwaaxxita ?		
307	Hassibee lamfoolan ka illageen gambiaa hee'ukko	1 ooyya 2 aa'ee	Aa'ee ihulas xammich 309 mare
308	Ooyya ihulas mee'aa		

	abaroos qoodimmi ogora yoo xammicha	ooyya	Aa'ee
309	Hinkid awwaaxakamisa kurakaa		
310	Hassamoobee abaroos qoodimmi ogora howojja		
311	Hassamoobee abaroos qoodimmi ogora howojji bikkina kitaabaka uwwaka'a		
312	abaroos qoodimmi ogora hawwi hee'ulas hinkamma waarakkammida kuraa?		
313	Fayya'oom egechi mine affit ammane lomba uwwaa?		
314	Fayya'oom egechi egeroo manch haydinee hamanaatinee geegeesamtaa?		
315	Gaqqi maaxxaqa Fayya'oom egechi egeroo manch egeraa?		
316	Gaqqi maaxxaqa Fayya'oom egechi manch oracho moo'kkuyya egeraa?		
317	Kabala haydinee hamanaatinee fayya'oom egechch siiddaa?		
	Fayya'oom egech laboone ee hassanee		
318	Fayya'oom egach aman kiina makkoo? (ooyyaa ihulas 315 mare)	ooyya	Aa'ee
320	Fayya'oom egech beyyone hinkaa'n amane egetaa?		
321	Hinkid Fayya'oom egech beyyone eget aman moolaa?		
322	Ka ball hinkaa'n ammane egetaa? (daqiqane)		
323	Baxx amman keese awaadi lasgatisaa hee'ukko?		

Baxxanch IV awaaxxi egechcha

Fayya'oom egech mine waatteen illageen ki egechi hinkid hee'ukko?	Hore jora	Jora	mahayyome	Danaamo	horedanaamo
401	Fayya'oommi egech mi'n mucurooma				
402	Worafa egechi beyyi hararaa				
403	Fayya'oommi egech manch handine				

	gegeesaa					
404	abaroos qoodimmi oglluw ihaa					
405	Fayya'oommi egech manch caakisaa ki hawwo laa'aa					
406	Awwaaxxi bito'one					
407	Awwaado aa'lloom egeti ammane					
V. xeebi mu'llim xa'mmichcha		Horem iittummoyo	Iittumm oyo	mahayyome	Iittaamm o	Horem iittaamo
	Shiinaatamch xanato	1	2	3	4	5
501	Fayya'oommi egech manch handayatin gegeesaa					
502	Fayya'oommi egech manch ki bikkina beyyo uwaa					
503	Fayya'oommi egech manch makkaa					
504	Fayya'oommi egech manchine washi aaqanch yoo					
505	Fayya'oommi egech mancho amanitoo					
506	Fayya'oommi egech manchi aa'aaqancha					
507	Fayya'oommi egech manchi kiina oogatton beyyo uwwaa					
508	Fayya'oommi egech manchi ihaakoo lacho uwaa					
509	Fayya'oommi egech manchi caakiso'is aagoo					
510	Fayya'oommi egech manchi baxi ogora caakkisaa					
	Hegeeqi bikkina					
511	Fayya'oommi egechi mi'n muccurooma					
512	Worofa egerakam beyyi hararaa					
513	Fayya'oommi egechi min mishisoo					
514	Worofa egerakam beyyo hafachi aagoo					

	Fayya'oommi egech hara'mmaxx xaaxite					
515	Fayya'oommi egech min yoo beyyi					
516	Awwaado aa'lloom egeti ammane					
517	kilinicane hiinkaa'n ammane egettaa					
518	Kiliniiq baxxi ammani					
519	Xuunso abaroosa qoodimane hinkaa'na galaxxitaa					
520	Qoondum qoodo ammane waatto?					

ASSURANCE OF THE PRINCIPAL INVESTIGATOR

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

Name of the student: TSEGAYE GEBRE

Date _____ Signature _____

APPROVAL OF THE ADVISORS

Name of the first advisor: Professor Kifle Woldemichael

Date _____ Signature _____

Name of the second advisor: Mr. Sena Belina

Date _____ Signature _____

APPROVAL OF THE EXAMINE

Name of the internal examiner Sr.Bosena Tebeje

Date _____ Signature _____