Assessment of Quality of care in Family Planning services in Gambella Town Public Health facilities, Gambella regional State, Southwest Ethiopia, 2011.

By

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A Research thesis Submitted To Jimma University, Collage of Public Health and Medical sciences, Department of Epidemiology and Biostatistics, in Partial Fulfilment of the Requirement for a Masters Degree of Public Health (MPH) in General Public Health.

March 2011

Jimma University, Ethiopia

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March 2011

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Abstract

Background: Good quality family planning services helps individuals and couples meet their reproductive health needs safely and effectively**.** Quality family planning service is also an important determinant of acceptance and continuation rates, and therefore a major contributor to increase the number of contraceptive users and sustainability of the services.

Objective: To assesses Quality of care in Family Planning services in Gambella Town Public Health facilities, Gambella regional State, Southwest Ethiopia.

Methods: Facility based cross-sectional study using both quantitative and qualitative methods of data collection was conducted in March 2011. A pre-tested structured close-ended questionnaire for client exit interview, and structured checklist for observation of client-providers' interaction and facility audit was used for quantitative data collection. A total of 422 clients for exit interview and [22] FP counseling session was systematically included in the study unit. A semi-structured in-depth interview guide was used to capture relevant information from key informant.

Result: The most commonly used family planning method was the injectable, 351 (83.8%), followed by the pill, 65 (15.4%). Large proportion, 337 (80.2%), of clients were not well-informed about the side effect of the method and 331 (78.9%) of clients were also not informed what to do if they faced problem with the method. Two hundred thirty (54.8%) of clients were not advised as the method does not protect against HIV /AIDS & STIs. Similarly 284(67.3%) of clients were not encouraged to use condoms as a second methods. Majority, 394 (93.4%) of clients said that waiting time was reasonable and short to get services. As well as all of clients were informed when to return for follow-up visit and granted with reminder cards, 418(99.1%) of clients were also responded that they will come back for the next appointment. The overall clients' satisfaction with family planning service provision was found 257 (60.9%). There were acute shortage of different contraceptive methods, IEC materials, Copy of MOH guideline of family planning services in Ethiopia and lack of trained man power.

Conclusion: This study revealed several constraints in the provision of FP services with improved quality of care, which can be implied as area of possible improvement.

Acknowledgments

First and above all, I need to thank the almighty **Jesus** who helped me in all situations from beginning of my life up to today and my hope of all my future life.

Next, I would like to thank my Advisors Dr Sahilu Assegid for his contribution throughout this study.

I would also like to extend my thanks to Jimma University College of Public Health and Medical Science, Department of Biostatistics & Epidemiology for their contribution.

My special gratitude will also go to Mr. Shimeles Ololo and Mr.Mulusew Gerbaba for their valuable support during this study.

Moreover, Jimma University is highly appreciated for sponsoring my study and covering all my expenses.

My special thanks will also go to all my data collectors and respondents.

Lastly but not least, my thanks goes to Gambella Regional Health Bureau, Gambella Hospital and Gambella Town Health Centre for providing me valuable information for this study.

Acronyms

GRHB	Gambella Regional Health Bureau
EDHS	Ethiopia demographic health survey
FP	Family Planning
FGAE	Family Guidance Association Of Ethiopia
HC	Health Centre
HSDPs	Health Service Delivery Points
IEC	Information, Education, and Communication
ICPD	International Conference on Population and Development
IUCD	Intra Uterine Contraceptive Device
MCH	Maternal and Child Health
MOH	Ministry Of Health
NGO	Non-Governmental Organization
RH	Reproductive Health
SD	Standard deviation
WHO	World Health Organization

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Chapter One: Introduction

1.1 Background

Improving quality of family planning services offers many benefits; information and service will be accessible, clients make informed decisions, and public will have a more positive view of health care and its providers. Good quality family planning service helps individuals and couples meet their reproductive health needs safely and effectively (1).

The growing interest in the quality of reproductive health services over the last decade has emanate from a concern with the high levels of maternal mortality and morbidity in developing countries. Health professionals and organizations working in the developing world are now actively seeking more effective ways to prevent maternal deaths and improve women's health care. Quality health services in the developed world have been realized through an accumulation of improvements in the delivery of services as well as in the overall strengthening of medical education policies in terms of requirements for admission to medical school, curricula development and licensing (2).

Improving quality of care has been a necessary goal for family planning programmes worldwide. This increased interest has been accompanied with efforts to monitor quality of care at every level of service delivery (3).

Both availability and quality of family planning services are believed to have contributed to increasing contraceptive use and declining fertility rates in developing countries. There is general agreement that the quality of family planning and reproductive health services positively affects contraceptive use and behavior of the clients; and that clients deserve to receive safe and high quality services with respect and dignity (4).

Therefore, assuring quality of care in family planning services could assist to enhance family planning consumer and it could contribute to control maternal and child morbidity and mortality rate, unplanned pregnancies and population growth.

1.2 Statement of the problem

Studies in a number of countries indicated that wherever fertility is high, maternal, and infant and child mortality rates are high too. Each year approximately 550,000 women die during pregnancy or childbirth (5). Women's lifetime risk of dying of pregnancy-related causes in developed countries 1 in 2,800, developing countries 1 in 61, Sub-Saharan Africa 1 in 16 (6). Unsafe abortions account for 13% of all maternal deaths globally. The risk of abortion-related death is four times greater for an African woman than for an Asian woman, and 650 times greater than for a North American woman (7).

Data from the 2005 EDHS show that infant mortality has declined by 19% over the past 15 years from 95 deaths per 1,000 live births to 77. Under-five mortality has gone down by 25% from 166 deaths per 1,000 live births to 123 (8). Over 25,000 women and girls die each year due to pregnancy-related complications in Ethiopia. Maternal mortality ratio for Ethiopia for the period 1998-2004 is 673 deaths per 100,000 live births (9).

According to the United Nations official population estimates and projection in 2050, the world population will be in the range of 7.3 billion to 10.7 billion persons (10).

Sub-Saharan Africa has the highest fertility rate in the world, averaging 5.5 births per woman. In the region's mid-2007, population of 788 million is projected to increase to 1.2 billion by 2025. A big factor underlying high birth rates is the low use of modern contraception: only 16% of married women in sub-Saharan Africa use modern methods of family planning (11).

Ethiopia has the second largest population in sub-Saharan Africa after Nigeria, with an estimated 77 million people living there. According to projections by the Population Reference Bureau (PRB) in 2006, in the year 2050 the country's population will reach 145 million people, making it one of the 10 largest countries in the world (12). The total fertility rate for Ethiopia is 5.4 births per woman. The total fertility rate for Gambella is 4.0 per women. Percentage women who have begun childbearing at age of 15-19 are lowest in Addis Ababa (4%) and highest in Gambella Region (31%).

Today, an estimated 215 million women worldwide want to avoid pregnancy and plan their families but they and their partners are not using modern contraception (13). Reasons for unmet need are many: Services and supplies are not yet available everywhere or choices are limited, fear of social disapproval or partner's opposition pose formidable barriers, worries of

side effects and health concerns hold some people back; others lack knowledge about contraceptive options and their use. Millions more are using family planning to avoid pregnancy but fail, for a variety of reasons. They may not have received clear instructions on how to use the method properly, could not get a method better suited to them, were not properly prepared for side effects, or supplies ran out (14) .

Access to high-quality family planning and reproductive health services, including the control of sexually transmitted infections is a central and growing concern in sub-Saharan Africa today for many reasons. First, sub-Saharan Africa has the highest population growth rates of any region, averaging almost 3 percent per year, and governments are increasingly concerned about the adverse effects of such rapid population growth on development efforts. Women in Africa have children early and in large numbers, with completed family size averaging around six children. Second, an estimated 22 million women in the region have an unmet need for family planning services, meaning that they are not currently using family planning, but want to delay or avoid future pregnancies. Third, 40 percent of the world's 215,000 annual deaths among women in childbirth occur in the region (15). In 1994 in Cairo, at the, ICPD 179 countries agreed that: "…Reproductive rights embrace certain human rights that are already recognized... These rights rest on the recognition of the basic rights of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information, and means to do so, and the right to attain the highest standard of sexual and reproductive health... their right to make decisions concerning reproduction free of discrimination, coercion, and violence (16).

In Ethiopia due to rapid population growth, systematic provision of family planning service had begun in 1966, when small group of concerned individuals established the FGAE as Non-Governmental, non-profitable organization (17). In Ethiopia, Only 15% of women have a met need for family planning. In Gambella Percentage of currently married women with unmet need for family planning is 23.5, met need for family planning (currently using) is only 15.9, the total demand for family planning is 39.6, and Percentage of demand satisfied is 40.7(8).

This study may provide important information and baseline to family planning providers, policy makers, and program managers to improve quality of care in family planning services in the future.

Chapter Two: Literature review

Quality is an elusive concept. Definitions range from the vague (e.g. 'the totality of characteristics of an entity that bear on its ability to satisfy stated and implied need' (19). Good quality means, "Doing the right thing, at the right time, in the right way, for the right person - and having the best possible results" (20).

Quality in health care and family planning has been defined in many ways (21). From public health perspective, quality means offering the general health benefits, with the least health risk to the greater number of people, given the available resources. In addition, good quality means either meeting minimal standards for adequate care or achieving high standards of excellence. Quality can refer to the technical quality of care to the non-technical aspect of service delivery such as clients' waiting time and staff attitudes, and to programmatic elements such as policies, infrastructures, access, and management (22, 23, and 24).

Benefit of good quality

Assuring the good quality of service is an ethical obligation of health care providers. Research is beginning to show that good quality also offers practical benefits to family planning clients and programs (25).

Safety and effectiveness: -Good qualities make contraception safer and more effective. If poorly delivered, some family planning service can cause infection, injuries, and in rare cases death. Poor services also can lead to incorrect, inconsistent, or discontinued contraceptive use (26). Good quality of care in family planning service is effective, because, it helps to inform clients fully; screen client for medical eligibility, clients choose for the methods that suit their individual circumstances, teach clients how to use their methods properly, and support clients when they encounter problems or decide to switch methods.

Greater client satisfaction and continuation*:* Good cares attract, satisfy, and keep clients by offering them the service, supplies, information, and emotional support they need to meet their individual goals. Different Studies found that good quality of family planning services encourage people to continue using contraception when they want to avoid pregnancy.

Study conducted in China show that, women were far more likely to continue using injectable contraception when they had been thoroughly counseled on how the method works and its side effects. Only 11% of women receiving good counseling had dropped out in one year compared with 42% of women receiving limited counseling (27).

Study conducted in rural Bangladesh, were indicated that the most powerful predictor for client satisfaction with the government services was provider behavior, especially respect and politeness. For patients this aspect was much more important than the technical competence of the provider. Furthermore, a reduction in waiting time (on average to 30min) was more important to clients than a prolongation of the quite short (from a medical standpoint) consultation time (on average 2 min, 22 sec), with 75% of clients being satisfied (28).
Study conducted in Malawi was found that, Less than 50% of clients felt there was privacy during counseling and examinations. Individual counseling of clients was not done (as low as 25%). Inadequate supplies at times, not all providers give return dates (29).
Empirical support for the hypothesis that quality of care is an important determinant of contraceptive continuation is available from Africa and Asia. Specifically, information provided during a consultation is positively associated with contraceptive continuation: Users who are adequately counseled are more likely to continue practicing contraception than those who are not adequately counseled. In a study of contraceptive discontinuation in Niger and the Gambia, researchers reported that approximately 30% of new family planning clients discontinued contraceptive use within the first eight months of acceptance (Cotten et al. 1992). The principal reasons given for discontinuation included side effects, spousal separation, spousal disapproval, and the desire to have a child. This study also noted that discontinuation was higher among women who reported that they had not been adequately counseled about contraceptive side effects: for instance, in Niger, 37% of the women who reported inadequate counseling discontinued use, whereas among women reporting that they had received adequate counseling, only 19% discontinued use. A similar situation was encountered in Gambia, where 51 percent of those who felt they were not properly counseled discontinued use, compared with 14% of those who reported being well counseled. The authors concluded that contraceptive prevalence would be 7% points higher (from 16% to 23%) if all women lived in areas with the highest quality of care than in those areas with the lowest (30).

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

Once a client reaches the service delivery point; his or her decision to adopt or sustain contraceptive use is influenced by the quality of care provided. The unmet need, which refers to married women and unmarried adolescents who are sexually active may want to use contraception, but because of poor quality family planning service or expectation of poor service or some have been poorly treated at family planning clinic can keep them from using the service. Satisfied users will generate demand in the community and assist in the

recruitment of additional accepters. Without significant attention to quality, it would be difficult to lower fertility rates through voluntary means (17). Studies in Peru showed that Contraceptive prevalence rate would be 16-23% greater in all women lived in cluster with the highest quality service compared with the lowest (31). The decision to initiate and continue to practice contraception may depend on the quality of care available to women, in particular the choice of methods provided, the information elicited for the women and communicated to her, and the nature of personal treatment given (31). Existing literature and analysis suggest that improvement in quality of family planning service by enhancing the choice of contraceptive methods available in a country would increase the overall practice of contraception and thus would result in fertility reduction (17).

In a large study of women in Zimbabwe, which has the second highest rate of contraceptive use in sub-Saharan Africa, women who started using family planning at a younger age were more likely to be working outside the home. About 92% of women in the study said that family planning influences women's success (32). Study conducted in Kenya were found that, Client satisfaction was generally high and only 9 % of the clients could be considered less than satisfied. About 10% of the clients were not happy with issues on privacy, about 12% with explanations about method, and 25% with availability of medicines or methods. The waiting time to receive services at the facility was considered one of the worst aspects of service provision (33).

Studies regarding status of quality of care in FP service in Ethiopia are not carried out sufficiently. However, Study conducted in East Show Zone, Oromia Regional State, Ethiopia were found that FP clients to be (very) satisfied by the quality of the FP service they received. However, they indicated that providers did not discuss with them on their fertility desire (76.9%), FP methods (56.3%) and the side - effect of the specific FP they took (67.7%). In addition, significant proportion of clients did not understand the information provided by the FP service providers (27.9%) (34).

Study conducted in Gondar, northwest Ethiopia was found that, the majority of the clients (66.3%) responded that there was no adequate privacy in service provision sessions. About 18% said that it was difficult to understand the service provider or that she or he did not hold any discussions at all. Communication and privacy was worse in government institutions compared to the NGO clinic included in this study ($P<0.05$). About 98.5% of the clients were not asked about STD risk and only 3.0% of the respondents were advised to use condoms.

The providers mentioned several unjustified restrictions (like menstruation, age, marital status, husband's consent) in which cases; they did not provide family planning methods. Deficiencies were also noted in the provision of information and communication with clients, infection prevention procedures, and adequacy and cleanliness of service giving facilities (35).

Study conducted in Jimma, showed that, 69(10.9%) and 14(8.1%) of those who reported problems expressed dissatisfaction with waiting time and solution given by providers respectively. Method unavailability was the reason in most services delivery points for providing methods different from client choice. In this study, again provider's special training and time of training have shown significant difference on quality of indicators (36).

Another study in Addis Ababa has shown that shortage of logistics and supplies, poor clients' record, inadequate supervision, poor counseling service, and long waiting time were major constraints to satisfy clients. These and other studies in developing countries showed that, the presence of low quality of family planning service contributes to lessened service utilization (17, 37).

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

2.1. Conceptual frame wok of the study

In this study, the J. Bruce (1990) framework was used, which is the central paradigm for the assessment of quality of care in international family planning and has large number of components that enables to assess different aspects of service quality. It defines quality of care in terms of six fundamental elements such as Choice of contraceptive methods, Information given to clients, Provider competence, Client-provider interaction, Re-contact, & follow-up mechanism and appropriate constellation of service (22). In this, study five fundamental elements i.e. choice of contraceptive methods, Information given to clients, Provider competence, Client-provider interaction, Re-contact, & follow-up mechanism was addressed to assess quality of care in family planning services.

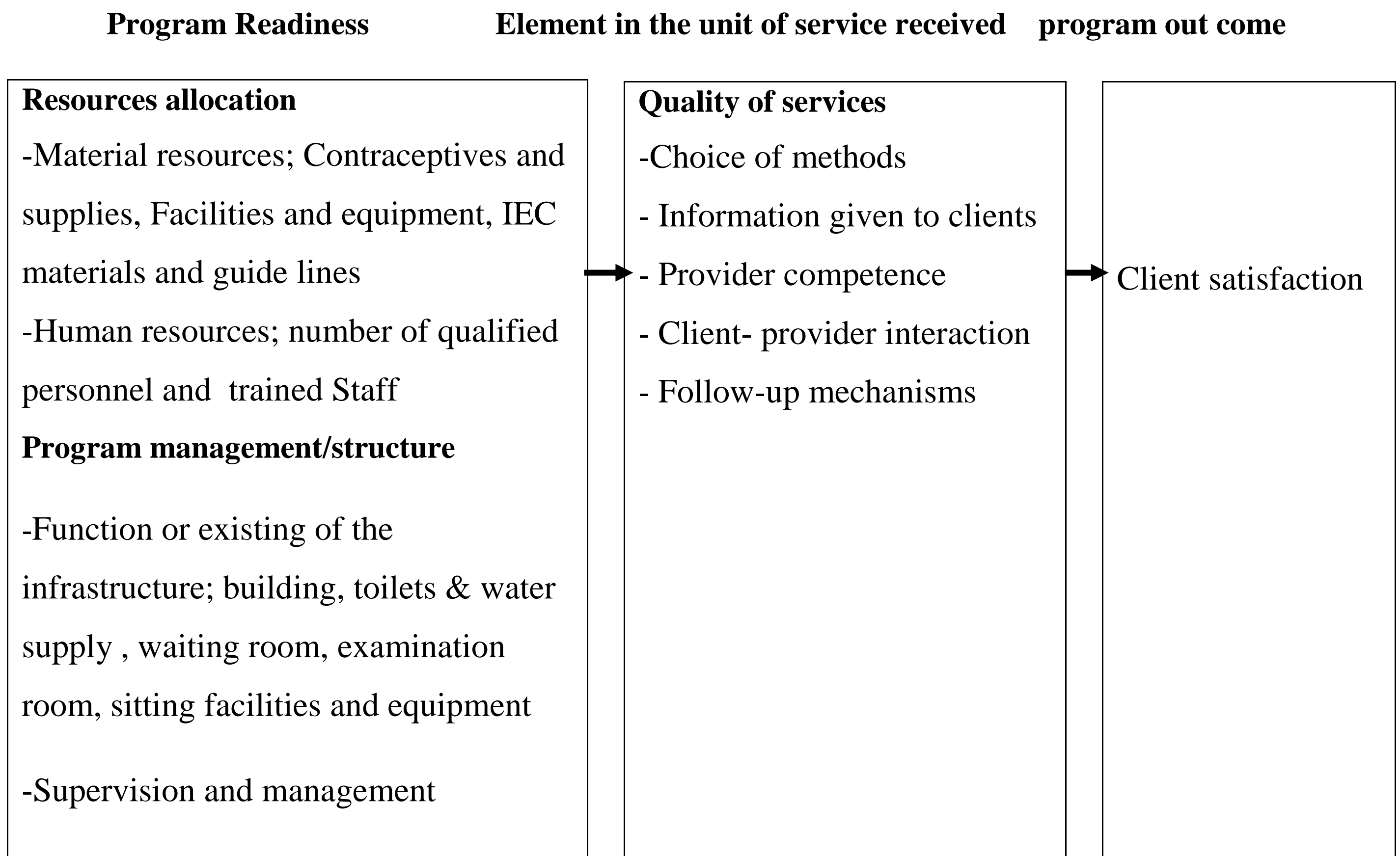

Figure 1 : Conceptual Framework on Quality of Care in family planning services (22).

Chapter Three: Significance of the study

The focus of attention on health service in developing world including Ethiopia has been generally directed toward improving coverage rather than quality of services. Lately, however, awareness of this problem has increased, and experts have pointed out the need to let developing countries gain from the progress made in the field of quality assurance. Several studies have shown that quality of care greatly influences the uptake and continuation of use of family planning services.

So-far evidence based data related to quality of care in family planning services and reproductive health are inadequate in the study area. Additionally quality of care in family planning services and utilization were not well studied in the study area and still there is under utilization of family planning services.

The result of this study will help in addressing critical points for the improvement of contraceptive prevalence rate and reduction of high fertility rate in the study area. The outcome of this study will be also addressed the problem of family planning and reproductive health program and management. Generally the conclusion of this qualitative study will be used for the improvement of quality of care in family planning and reproductive health in the study area.

Chapter Four: Objectives of the Study

4.1 General objective

- To assess quality of care in family planning services in Public health facilities in Gambella Town, Gambella Regional State,2011.

4.2 Specific objectives

1. To determine level of client satisfaction with the Family planning services
2. To describe - client-provider interaction in Family Planning services
3. To assess the availability and adequacy of logistic and supplies for FP services
4. To assess factors that affect quality of care in Family planning services

Chapter Five: Methods and Materials

5.1. Study Area and period

The study was conducted in Gambella Hospital and Gambella Town Health Center in March 2011. Gambella is the Capital City of Gambella Regional State. The Region covers a total area of 23,127sq.km. Gambella town is located at 777-km from Addis Ababa, in the southwest direction. According to 2007 National census, the region has a total population of 306,916, similarly; the total population of the town was 40,968 among which 9833 of them were women of reproductive age group.

Administratively, the region is divided in to three zones and one especial woreda called Ethang. There are about thirteen woredas (districts) in the region having different ethnic groups and the regional official working language is Amharic. The majority of ethnic group residing in the region are Nuer, Agnuak, and Mezhenger. However, there are also other ethnic groups including settlers from other parts of the country (Oromo, Kembata, Guraghe, Tigre, and Amhara) and refuges from the southern Sudan. The region has 1 hospital, 8 health centers, sixty-six health post, and seven private clinics (38).

Gambella Hospital was established in 2008, with a compound of 12,100 m2 areas and built on 7000 m2 area and has 65 rooms, and run by the regional health bureau. As the only hospital in the region, provide various health services, including FP service. General outpatient morbidity statistics indicated that an average of more than 200 new outpatient clients served every day in the hospital. The hospital has 88 technical personnel including gynecologist, five general medical practitioners, seven-health officer, fifty-two nurses, and one midwifery.

According to information obtained from Gambella regional health bureau, average clients flow for family planning service were, 25 per each working day in Gambella hospital and 14 per each working day in Gambella town health center [on average a total of 858 clients] flow for FP services per month (twenty-two working days) from Monday to Friday in both health facilities (39).

5.2. Study design

Facility based cross-sectional study.

5.3. Population

5.3.1. Source population:

For quantitative study: - all women of reproductive age group in Gambella town.

For qualitative study: - all health workers and program managers on FP service in Gambella town.

5.3.2. Study population:

For quantitative study: - all women of reproductive age group in Gambella town who came only to get family planning services during the data collection period in public health facilities in Gambella town and included in the sample.

For qualitative study: - [all], FP service providers, head of pharmacy department and FP coordinators who were available during the data collection time, in Gambella town public health facility.

5.3.3. Inclusion & exclusion criteria

Inclusion criteria

All clients who came only for FP services in public health facility during the time of data collection period were included in the study.

Exclusion criteria

Those clients who have impaired hearing of family planning service users during the time of data collection period were excluded from the study.

5.4. Sample size determination & sampling techniques

5.4.1. Sample size determination for exit interview

The sample size was calculated using single population proportion formula, taking the proportion of FP users' satisfaction as 50%, and allowing 5% of margin of error the sample size calculated was 384.

The formula for calculating the sample size was,

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

Where:

n=the desired sample size

P= proportion of clients satisfaction 50%

$Z\alpha/2$= critical value at 95% confidence level of certainty (1.96)

d= the margin of error between the sample and the population (5%)

Allowing 10% of the calculated sample size for non response rate, the total sample size was 422.

5.4.2. Sampling techniques

[Client exit interview]: A systematic sampling technique was employed to recruit client of FP service users from the source population who were available during data collection period. According to information obtained from Gambella regional health bureau, average clients flow for family planning service were, 25 per each working day, (550 per month) in Gambella hospital, and 14 per each working day (308 per month) in Gambella town health center. On average a total of 858 clients were flow for FP services per month [twenty-two working days] from Monday to Friday in both facilities. The overall sample size determined for exit interview were 422 family planning service users. The sampling fraction was [858/422=2; hence, the sampling interval was 2]. The first client to be interviewed was selected randomly by lottery method blindly picking one out of two pieces of paper, numbered 1 to 2. Number 2 was picked and the regular intervals of every two client were interviewed, starting with the second client, until 422 clients were interviewed.

A proportional to size allocation was employed to allocate clients for exit interview from both facilities. Then [422/858X550 = 271] clients were recruited from Gambella hospital, while [422/858X 308 = 151] clients were recruited from Gambella town health center].

[Client provider-interaction observation]: A systematic sampling technique was employed to recruited client for observation sessions from the overall determined sample size of FP service users. Since the data collection period was 22 working days [422/22+2=22] consultation session were recruited for client provider interaction observation. A proportional to size allocation was employed to allocate observation session for both facilities. Then [271/422 X 22 = 14] observation session were recruited for Gambella hospital, while [151/422 X 22 = 8] observation session were recruited for Gambella town health center. The sampling fraction was [22/22 = 1 hence, the sampling interval was 1 day]. The observation session was selected randomly by lottery method blindly picking one out of eight pieces of paper, numbered 1 to 8 by considering eight minimum clients flow each day. Number 4 was picked and the fourth consultation session was regularly observed, until 22 consultation sessions were observed depending on saturation [tentatively].

Facility audit: - all facility audit &/or inventory were conducted to assess the availability and functionality of all equipment and relevant resources (logistic and supplies) for FP service provision in the studied health facility.

In-depth interview: - Regional FP program coordinator, pharmacy heads and all FP service providers, who have been regularly working in the FP service unit, were first identified. Then two FP service providers and one pharmacy head from Gambella hospital, two FP service providers and one pharmacy head from Gambella town health center and one Regional FP program coordinators from RHB were purposively included in the in-depth interview.

5.5. Data collection procedures

5.5.1. Instruments

After reviewed of relevant literatures based on J.Bruce conceptual framework, a standardized questionnaire was adapted, adjusted and used for data collection (40). The questionnaire was originally developed in English (Annex-I), and then translated in to Amharic (Annex-V) and re-translated to English to assure its consistency by different individuals.

[Client exit interview]:- structured close-ended questionnaire was used for interviewed client of FP service users. The format of questionnaire for exit interview was consisting of a yes/no format questions, Likert type and other format to picture client perspective on the quality of service provision. In other format, lists of alternatives were given to clients and they were asked to response their experience concerning the service provided them. This instrument provided information about the quality of services received from the client's perspective.

[Observation]: - a structured observation checklist was used for observation of client-provider interaction and facility audit.

[In-depth-interview]: - semi-structured in-depth interview guide was used for in-depth interview for qualitative study.

5.5.1.1 Pre-test

The questionnaire was pre-tested before the actual data collection. It was pre-tested in one public health facility, in Gambella Region but outside the town, [Ethang health center], which was later not included in the study to ensure the clarity of the questionnaire. Five percent of the total sample size, [21 clients] of family planning service user’s for exit interview, and two family planning counseling session provided for clients of family planning service users available during data collection period was included in the pre-test for quantitative study.

One family planning service provider and head of pharmacy department who were available during the data collection period were purposively included in the pre-test for qualitative study. The result of the pre test was discussed & some corrections and changes were made on the questionnaires based on the result of the pre-test.

5.5.2. Personnel

Two 3rd year clinical Nursing students and fluent Amharic speakers from Gambella Health Science Collage and two local language speakers trained research assistant fluent in Amharic from Gambella Regional Health Bureau were recruited for client exit interview data collection.

Two BSc. experienced Nurses from Gambella Health Science Collage and one BSc. Health Officer Supervisor from Gambella Regional Health Bureau was recruited for direct observation of client-provider interactions, in-depth interview and facility audit.

5.5.3. Data Collection

Client-exit-interview: - Full informed consent was obtained from all eligible participants after explained the objectives of the study to them. After obtained informed consent, data collectors were administered questionnaire to respondents in their own language. The exit interview was conducted in private room after they have got family planning service in the clinic. Information was collected on the client's experience about the service provision on their own perception.

[Client provider-interaction observation]:- Since data collectors were health professionals with clinical training, they wore a white coat and blend in to the service delivery point. Then observers were obtained permission from both providers and clients to be present during individual counseling and clinical examination. In the observation, a person with clinical training were followed client-provider interactions, and evaluated the performance of the provider during counseling and clinical sessions, thereby information was collected on technical competence in counseling and clinical procedures (including some items the client might not be able to judge).

[Facility audit]:- In addition, Availability & functionality of all equipment & relevant resources (logistic & supplies) for FP service provision were assessed with a person in charge. Information was collected on types of available methods and provided, types, and amounts of supplies in stock, the condition of the facility, the presence or absence of proper record keeping and documentation.

In-depth interview: - an in-depth interview was conducted by principal investigator with the collaboration of supervisor. All key informants were asked about all relevant resources (logistics and supplies) for FP service provision and workload, motivation, and training of the providers in the health facilities and their responses were recorded by the tep-recorder. Six in-depth interview sessions were conducted. A one-to one & half hours was spent per session.

5.5.4. Study variables

A. Dependant variable: -

Family planning service users' satisfaction

B. Independent variables are -

Provider competence

Information about methods

Client- provider-interaction

Follow-up mechanism

Accessibility (distance, Waiting time)

Availability of logistics and supplies

Infrastructure

Trained manpower

Socio-demographic variables of FP-service users (Age, marital status, educational status, religion and occupation)

5.6. Operational definitions

1. **Quality:** - in health care and family planning service, [offering a range of service that are safe, effective and that satisfied clients' needs and want].
2. **Quality of care in family planning services:** - client satisfaction, availability and functionality of facilities, supplies and equipments for family planning service provision.
3. **Logistics:** - Family Planning equipment, supplies, and physical set-ups like storage facilities for family planning service provision.
4. **Choice of methods**: - The freedom given to clients to choose a method according to their family planning intention, preference, and health status.
5. **Information given to clients**: - The information communicated to clients that enable to choose, and utilize contraceptive methods effectively.
6. **Waiting Time**: The time gap between the client's arrival at the HSDPs and the time client received family planning services.
7. **Provider competence**: - the skills, knowledge and experience of providers to provide family planning services.
8. **Clients-providers interaction: -** personal dimensions for service, principally the received affective contents of exchanges between providers and clients.

9. **Client Satisfaction:** clients' judgment of care received from family planning service providers / staffs and is acknowledged as an outcome indicator of quality of Care in this study.

5.7. Data management and analysis

The completed questionnaire was checked for completeness, consistency and was coded by the principal investigator. Data was entered in to SPSS version 16.0 software package for analysis. The result was presented using descriptive statistics including frequencies tables, percentages, graphs, mean, and standard deviation for variable under study. Then data clean up was done and checked for, accuracy, consistencies, & values. Any error then identified and corrected.

Likert type approach was provided to all clients with a statement asking them to indicate how strongly they disagree to strongly agree [having a scale of range **1** strongly disagree to **5** strongly agree] & their level of satisfaction was scored and indicated. The [mean score] was calculated and those who scored equal and above the mean were categorized under "satisfied" and those who scored below the mean were categorized under "dissatisfied."
The mean of summation of all the items used to assess satisfaction was used as cut of point to determine overall satisfied & dissatisfied clients
Then satisfaction was cross- tabulated using [chi-square test to look for an association between variables]. Odds ratio was also used to determine the strength of association of selected variables. Finally, binary logistic regression was applied to identify the confounding [effect] of each explanatory variable on the outcome variable using SPSS 16.0 window version software. Qualitative data was analyzed thematically.

5.8. Data quality assurance

The questionnaire was pre-tested before the actual data collection to ensure the clarity of questionnaire. The filled questionnaire was checked for its clarity, understandability, completeness, reliability, plus consistency and then correction was made accordingly.

A two day training, one day theoretical & one day practical, were given for data collectors and supervisors. Training was included briefing about the objective & relevance of the study, data collection tools and procedures, how to approach potential respondents and how to keep confidentiality later. Additionally, the supervisor was oriented on coordination and data quality management.

Full informed consent was obtained from all eligible participants after explained the objectives of the study in their own language. After obtained informed consent, all data collectors were verbally administered questionnaire to respondents in their own language. The exit interview was conducted in private room. Data collectors were instructed to check the completeness of each questionnaire at the end of each interview. The principal investigator together with supervisor was rechecked completeness of the questionnaire immediately after interview at field level and during submission.

Data cleaning was done thoroughly by running frequency of variables using SPSS version 16.0 soft ware program by the principal investigator before analysis.

5.9. Ethical Consideration

Before the fieldwork, ethical clearance was obtained from the Ethical Review Board of Jimma University College of Public Health & Medical Sciences and official letter of co-operation was sent to Gambella Regional Health Bureau. Then formal letter of cooperation was written from Gambella Regional Health Bureau to each service delivery points [Gambella hospital and Gambella town Health center]. Response of clients was anonymous and data collectors were informed the clients that they have full right to discontinue or refuse to participate in the study at any point if they do not feel comfortable.

All interviews were carried out with absolute privacy, and informed verbal consent was obtained before administering the interview.

5.10. Dissemination and utilization of finding

Primarily the final report will be presented to College of Public Health and Medical Sciences, at Jimma University. After approval of the report by Jimma University, it will be disseminated to studied health facilities, Gambella region health bureau, interested sectors, and other stakeholders working on Family planning and Reproductive health. The extracts of the article will be sent to journals for possible publication.

Chapter Six: Results

6.1. Exit Interviews

6.1.1. Background characteristics of study subjects

A total of 422(100%) clients were included in the exit interview. [Out of these 338(80%) were continuing clients, 67(15.9%) new clients and 17(4.1%) switching clients]. Majority of clients, 248 (58.8%), were in the age group of 20-29 years. The mean age of clients was 25.9 years (median 25 and the range was 16-44); 379(89.8%) of clients were married, 336 (84.2%) of clients were discussed on family planning with their husband, and 318(75.4%) had children, out of these 301(94.7%) had 1-4 children, others had 5 and above, 107 (33.6%) mothers were breast feeding at the time of data collection. Out of 131(41.2%) clients who wanted to have children, 78(59.5%) of them were desired to have children after 3-4 years.

Most of clients, 277(65.6%), were traveled <1/2 an hour to arrived at the HSDPs and 145(34.4%) of clients were traveled 1/2 to 1 hours. Orthodox religion followers were predominant, 174 (41.2%), and followed by Protestant Christian, 132(31.3%). Majority of the ethnic group were Oromo, 116(27.5%), and completed primary schooling, 144(34.1%). Relatively most of the respondents, 170 (40.3%), were housewives.

The mean monthly family income was 1028.00 E. Birr (median 820.00 E. Birr and range 100.00- 4200.00 E. Birr and the majority, 69(33.2%) of clients have monthly incomes 721-1000.00 E. Birr **(Table: 1).**

Table 1: Background characteristics of family planning service users in Gambella town public health facilities, March 2011 (n=422).

Characteristics	Number (%)
Age	
15-19	69 (16.4%)
20-29	248 (58.8%)
30-39	90 (21.3%)
40-49	15 (3.6%)
Marital status	
Single	23 (5.5%)
Married	379(89.8%)
Divorced	16 (3.8%)
Widowed	4 (0.9%)
Religion	
Orthodox	174 (41.2%)
Protestant-Christian	137(32.5%)
Muslim	65(15.4%)
Catholic	46(10.9%)
Educational Status	
Illiterate	84(19.9%)
Read and write only	39(9.2%)
Primary school(1-8)	144(34.1%)
Secondary school(8-12)	97(23%)
Twelve and above	58(13.7%)
Occupational status	
Government employee	66(15.6%)
Private employee	25(5.9%)
Merchant	30(7.1%)
Unemployed	39(9.2%)
Housewife	170(40.3%)
Student	73(17.3%)
Daily labourer	13(3.1%)
Others	6(1.4%)

Table-1 con'd

Ethnicity	
Agnuak	54(12.8%)
Nuer	26(6.2%)
Oromo	116(27.5%)
Kembata	53(12.6%)
Guraghe	26(6.2%)
Tigre	33(7.8%)
Amhara	77(18.2%)
Other	37(8.8%)
Distance from client home to HSDPs	
<1/2hrs	277(65.6%)
1/2 - 1hrs	145(34.4%)
Number of live birth (n=318)	
0	104(24.6%)
1-3	249(59.0%)
4-12	69(16.4%)
Clients desired to have more birth (n=131)	
From (1-2 years)	22(16.8%)
From (3-4 years)	78(59.5%)
After 4 years	20(15.3%)
Monthly income (n=208)	
<=250	4(1.9%)
251-500	35(16.8%)
501-750	45(21.6%)
751-1000	69(33.2%)
>1000	55(26.4%)

6.1.2. Exit Interviews on Service provision

The most commonly used family planning method was the injectable, 351 (83.8%), followed by the pill, 65 (15.4%) (Figure-1). [Out of 355 continuing clients, 208 (58.6%) of clients were not asked if they reported problem with methods, 91(25.6%) of clients were reported problem with the method they used of which only 50 (54.9%) of clients were satisfied with the advice or solution provided them to resolve their problem, while 41 (45.1%) of clients were not satisfied with the advice or solution provided them to resolve their problem]. Almost all, 412 (98.1%), of clients were getting their method of choice while 7 (1.7%) of clients have no preference.

Out of 65 client who were using pills, 56 (86.2%) of clients reported that the provider explained to them on how to use the method. Of the total respondents, 337(80.2%), of them were not well-informed about the side effect of the method, and 331 (78.9%) of clients were not informed what to do if they faced problem with the method they used. [Similarly, 230 (54.8%) of clients were not advised as the method does not protect against HIV /AIDS & STIs, and only 185 (44.0%) of clients were advised as the method does not protect against HIV /AIDS & STIs]. All of pills users knew how to use pills; injectable users also knew how long injectables provide protection against pregnancy. All clients who used condom knew how many times a condom can be used at the same time as client who received Norplant knew how long Norplant provide protection against pregnancy.

Majority, 250 (59.2%), of clients were waiting 16-30 minutes to get service. The rest 115 (27.3%) and 45 (10.7%) of clients waited for <=15 minutes and 31-40 minutes respectively. Considerable proportion, 394 (93.4%), of clients said that waiting time was reasonable and short to get services, whereas only 28(6.6%) of clients were reported long waiting time.

Of all clients, 392 (92.9%) were responded that Opening time was convenient but Opening time was not convenient for 23 (5.5%) of clients. It was also found that 287 (68.0%) of clients were discussed about HIV/AIDS &STIs, while 124 (29.4%) of client were not discussed during the service provision session. More than half, 284 (67.3%), of clients were not encouraged to use condoms as a second methods and only 135 (32.0%) of clients were advised to use condoms as a second methods.

Two hundred forty nine (59.0%) of client were comfortable to ask question during counseling session, while 164 (38.9%) of respondents were not comfortable to ask question.

Majority, 295(69.9%), of clients feel that the information provided to them was about right, where as 81(19.2%) of client feel that the information provided to them was too little, and others, 46(10.9%), of clients could not judge. Ninety (21.3%) of client were said that the information discussed with provider was heard by others, while 295(69.9%) of clients responded that the information discussed with provider was not heard by others and 37(8.8%) of clients could not judge. More than half, 224 (53.1%), of clients believed that the provider kept information confidential, while 85 (20.1%) of client not believed that the provider kept information confidential and others, 113 (26.8%), could not judge.

Three hundred eighty eight (91.9%) of clients were well treated by the provider during their visit, and only 17(4.0%) of clients were very well treated which was consistent figure with those who reported not very well treated during their visit. Almost all, 405 (96.0%), of clients were well treated by other staffs during their visit, where as only 11(2.6%) of clients reported as they were not very well treated. Three hundred nineteen (75.6%) of clients feeling on consultation with clinical staff were about right, while 64 (15.2%) of clients feel too short and others, 33 (7.8 %), of client could not judge. For 362 (85.8 %) of the women, the provider was easy to understand, 33 (7.8 %) of clients said the provider was difficult to understand and 26 (6.2%) of them said they did not understand most of the things that the provider discussed. All clients were informed when to return for follow-up visit and granted with reminder cards. At the same time, 418(99.1%) of clients responded that they will come back for the next appointment.

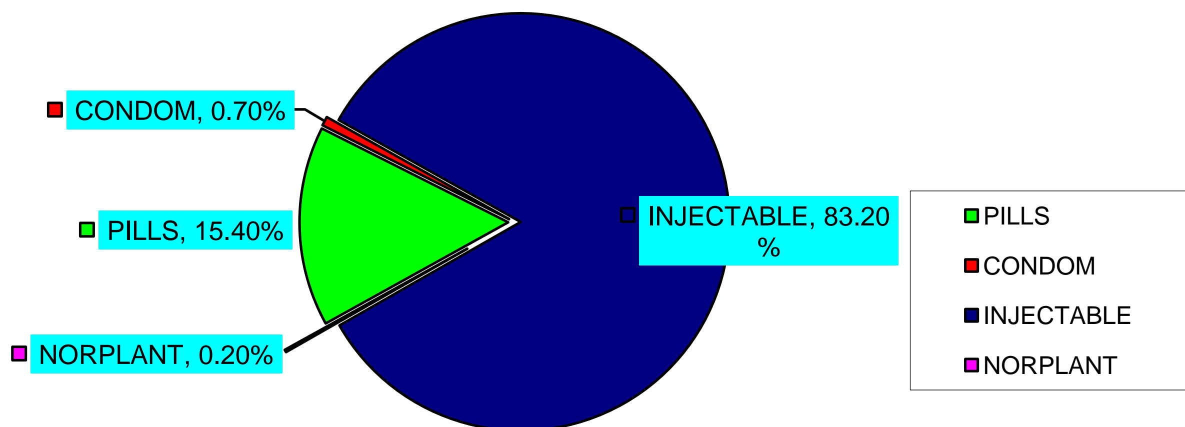

Figure 2: Contraceptive Methods Received by clients in Gambella town public health facilities, March 2011.

Table 2: Service delivered to FP service users in Gambella town public health facilities, March 2011.

Characteristics	Number (%)	
Medical Information (n=355)	**Yes**	**No**
Provider ask clients' problem with method	147 (41.4%)	208 (58.6%)
Client faced problem with methods	91 (25.6%)	264 (74.4%)
Medical Information (n=91)		
Provider understand client problem	54 (59.3%)	37(40.7%)
Provider suggest client action to resolve problem	51 (56.0%)	40(44.0%)
Client satisfied with received advice on problem	50 (54.9%)	41 (45.1%)
Received method of choice (n=420)		
Client did receive their method of choice	412 (98.1%)	1(.2%)
Information on methods (n=422)		
Provider describe possible side effect	78 (18.6%)	337(80.2%)
Provider tell client what to do for problem	80 (19.0%)	331(78.8%)
Explain the method does not protect against HIV/AIDS	185(44.0%)	230 (54.8%)
Information on how to use methods (n=65)		
Provider explain effectively how to use the method	56 (86.2%)	9(13.8%)
Opening hours of HSDPs (n=422)		
Opening hours convenient for client	392 (92.9%)	23(5.5%)
Privacy and service provisions (n=422)		
Client comfortable to ask question during counselling	249 (59.0%)	164 (38.9%)
Client believe that the provider kept information confidential	224 (53.1%)	85 (20.1%)
STI and HIV/AIDS were discussed	287(68.0%)	124(29.4%)
Client encouraged to use condom as secondary method	135(32.0%)	284(67.3%)
Other clients hear what client talk during consultation	90(21.3%)	295(69.9%)
Client feel about waiting time (n=422)	**Number (%)**	
Reasonable and short	394(93.1%)	
Long	28 (6.6%)	
Cannot judge	113 (26.8%)	

Table-2:con't

Information given clients during their visit (n=422)	
Too little	81(19.2%)
About right	295 (69.9%)
Cannot judge	46(10.9%)
Client treated during their visit by the provider (n=422)	
Very well	17 (4.0%)
Well	388 (91.9%)
Not very well or poorly	17 (4.0%)
Client treated during their visit by other staffs (n=422)	
Very well	6 (1.4%)
Well	405 (96.0%)
Not very well or poorly	11 (2.6%)

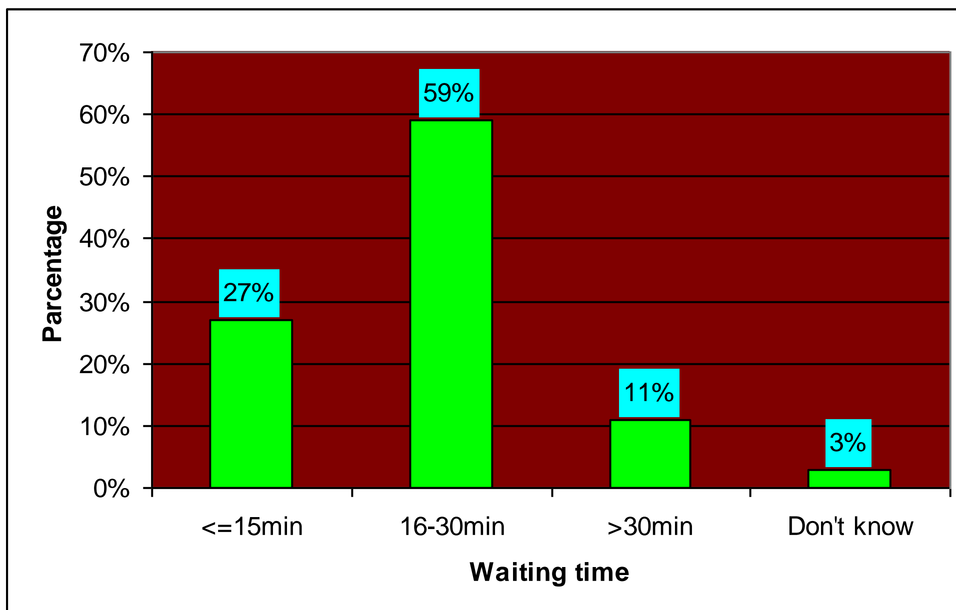

Figure 3: Client waiting time to get FP Services in Gambella town public health facilities, March, 2011.

6.1.3. Level of clients' satisfaction on service provision

The proportion of clients who expressed satisfaction with opening time of service was very high, 399 (94.5%) of total clients. Similarly, 420 (99.5%) of clients were also satisfied with waiting time. Considerable proportion of clients, 398 (94.3%), were dissatisfied with the adequacy of water supply at waiting area, while 292 (69.2%) of clients were satisfied with ease of use toilet around waiting area. Majority, 301 (71.3%), of clients were satisfied with welcoming and respect of provider however; 244 (57.8%) and 291 (69.0%) of clients were dissatisfied with perceived competency of provider and counseling provided to them, respectively.

Two hundred eighty (66.4%) of clients were satisfied with perceived empathy, but 292 (69.2%) of clients were dissatisfied with the information provided to them on the method. Large proportion, 347(82.2%), of clients were satisfied with maintenance of privacy during service provision or counseling. Generally the overall clients' satisfaction with family planning service provision was found to be 257 (60.9%), while 165 (39.1%) of clients were dissatisfied with family planning service provision as shown in Figure-3 below.

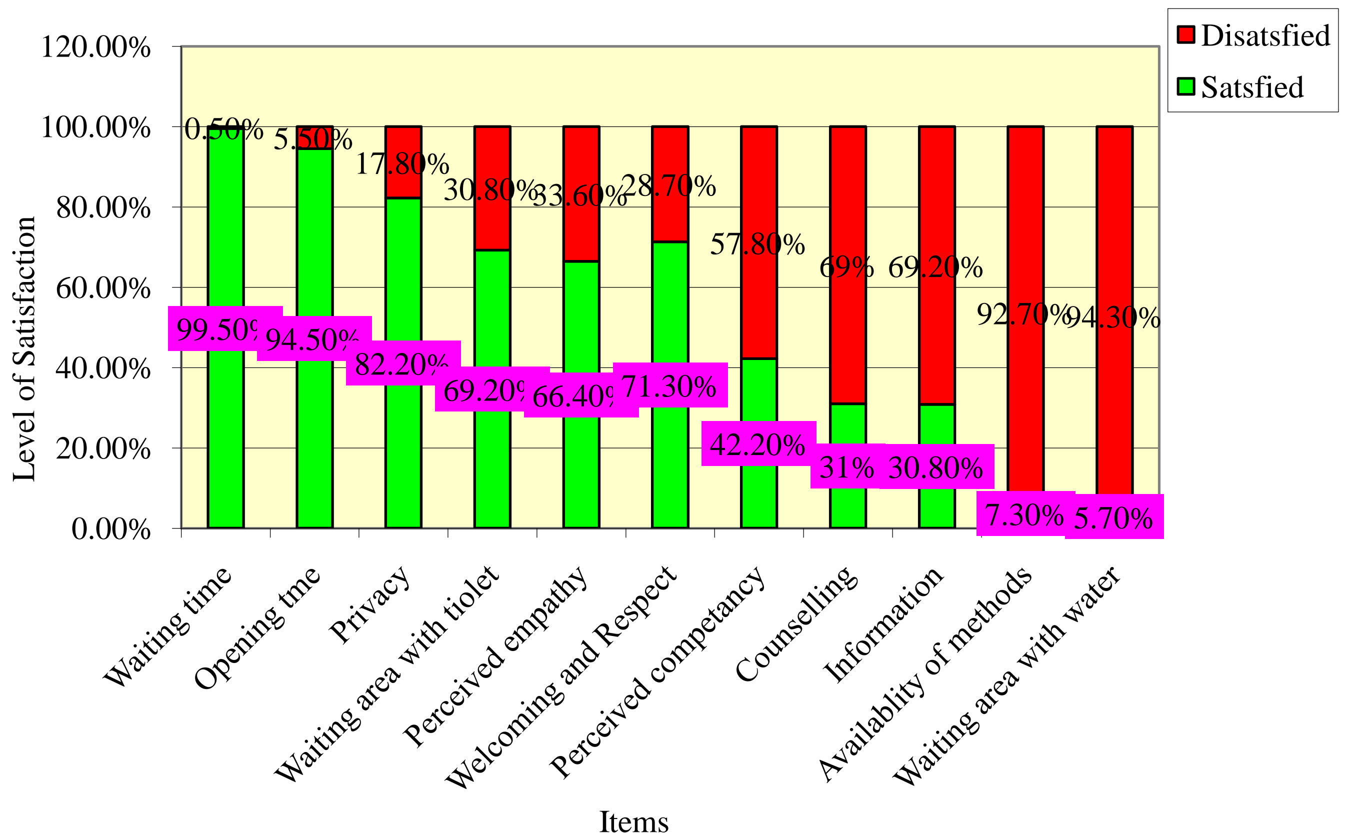

Figure 4: Level of Client satisfaction on service provision in Gambella town public health facilities, March 2011

The mean of summation of all the items used to assess satisfaction was used as cut of point to determine overall satisfied and dissatisfied clients. When the effect of educational status, age, Religion, Ethnicity, Occupation, and waiting time were considered on being satisfied and dissatisfied, using backward likelihood binary logistic regression analysis, none of them were found to have statistically significant effect**(Table -3).**

Table 3: comparison of selected background characteristics of clients with the overall satisfaction on FP services in Gambella town public health facilities, March 2011.

Characteristics (n=422)	**Over all satisfaction**		**COR(95% CI)**
	Satisfied	**Dissatisfied**	
Marital status of clients			
Single	12	11	1.00+
Married	229	150	1.40(0.60-3.52)
Divorced	13	3	3.97(0.90-17.78)
Widowed	3	1	2.75(0.25-30.51)
Educational Status of clients			
Illiterate	59	25	1.00+
Read and write only	25	14	0.76(0.34-1.69)
Primary school(1-8)	88	56	0.67(0.38-1.18)
Secondary school(9-12)	53	44	0.51(0.28-0.94)
Twelve and above	32	26	0.52(0.26-1.05)
Religion of client			
Orthodox	105	69	1.00+
Protestant	84	48	1.15(0.72-1.83)
Muslim	38	27	0.93(0.52-1.65)
Catholic	27	19	0.93(0.48-1.81)
Others	3	2	0.99(0.16-6.10)
Ethnicity of client			
Agnuak	32	22	1.00+
Nuer	19	7	1.87(0.67-5.19)
Oromo	70	46	1.05(0.54-2.02)
Kembata	35	18	1.34(0.61-2.93)
Guraghe	15	11	0.94(0.36-2.42)

Table-3:Con'd

Tigre	22	11	1.38(0.56-3.40)
Amhara	40	37	0.74(0.37-1.50)
Others	24	13	1.27(0.53-3.02)
Occupational status of client			
Government employee	34	32	1.00[+]
Private employee	18	7	2.42(0.89-6.56)
Merchant	21	9	2.20(0.88-5.50)
Unemployed	22	17	1.22(0.55-2.70)
Housewife	106	64	1.56(0.88-2.77)
Student	43	30	1.35(0.69-2.64)
Daily labourer	8	50	1.51(0.45-5.09)
Commercial sex workers	4	1	3.77(0.40-35.50)
Age of client(in years)			
15-19	43	26	1.00[+]
20-29	150	98	0.93(0.53-1.60)
30-39	54	36	0.91(0.48-1.73)
40-49	10	5	1.21(0.37-3.93)
Waiting time (in minutes)			
<=15	73	42	1.00[+]
16-30	153	97	0.91(0.58-1.43)
31-45	25	20	0.72(0.36-1.45)
Do not know	6	5	0.70(0.20-2.40)

+ Reference group

6.2. Client Provider Interaction Observation

A total of 4 providers (1 female and 3 male) were observed in two HSDPs while providing FP service to 22 clients. Of 22 observations, 8 were new and the rest 14 were continuing clients. In 18 (81.8%) of the cases provider greeted clients while in 4(18.2%) of cases provider did not greeted clients during the beginning of the session. In 19(86.4%) of cases provider ask clients open ended questions while only in 3 (13.6%) of cases provider did not asked open-end-questions. During consultation session, in 13(59.1%) of cases provider encouraged clients to ask question, where as in 9(40.9%) of cases provider not encouraged clients to ask question. In majority of the cases, 19(86.4%), provider treated client in respects. In the entire cases provider discussed a return visit and gave client some written reminder for follow up visit. In 16(72.7%) of cases provider not asked clients their concern with any method while only in 6 (27.3%) of cases provider asked clients their concern with any method. In all of cases providers not used visual aids during consultation session. In majority, 21(95.5%), of cases provider assured client confidentiality and all providers saw client in private.

During consultation session current age was not discussed in 18 (81.8%) of cases, current marital /relationship/ status was not discussed in 11 (50.0%) of cases, number of living children was not discussed in 16 (72.7%) of cases, desire for more children was not discussed in 19 (86.4%) of cases, timing of next birth was not discussed in 20 (90.9%) of cases, current pregnancy status was not discussed in 15 (68.2%) of cases, history of pregnancy complications was not discussed in 21(95.5%) of cases, partner's attitude about FP was not discussed in 21 (95.5%) of cases, multiple/single sexual partner was not discussed in 18 (81.8%) of cases, HIV/AIDS and STIs was not discussed in 16 (72.7%) of cases and history/signs/symptoms of STIs was not discussed in 20 (90.9%) of cases.

At the time of consultation, all of new clients stated their methods of choice and all were received. Method of preference for all new clients was Injectable. In all cases provider checked both pregnancy and blood pressure during provided injectable for new clients. It was found that 2(66.7%) of clients were told how to use pills, but the possible side effects of the received methods were discussed only for 2(25%) of new clients. Provider not explained method does not protect against HIV/AIDS &STIs in 21(95.5%) of cases and the same to that not encouraged client to use condom as second method or not provided condom with a method.

Washing hands with soap and water before and after performing the procedures was not conducted in all of the cases. In all cases sharp materials were disposed in sharp disposal containers. No referrals were made during the whole period of observation **(Table-4).**

Table 4: Observation of client provider interaction in Gambella town public health facilities, March 2011

Characteristics (n=22)	**Number (%)**	
Method actually received /New/Repeated client		
New clients	8 (36.4%)	
Repeated clients	14(63.6%)	
Injectables	19 (86.4%)	
Pills	3 (13.6%)	
Client provider interaction(n=22)	**Number (%)**	
	Yes	**No**
Provider greeted client	18 (81.8%)	4 (18.2%)
Provider asked open-ended questions	19 (86.4%)	3 (13.6%)
Provider encouraged client to ask questions	13 (59.1%)	9 (40.9%)
Provider treated client with respect	19 (86.4%)	3 (13.6%)
Provider asked clients their concern with any method	6 (27.3%)	16 (72.7%)
Current age discussed	4 (18.2%)	18 (81.8%)
Current marital /relationship/ status discussed	11 (50.0%)	11 (50.0%)
Number of living children discussed	6 (27.3%)	16 (72.7%)
Desire for more children discussed	3 (13.6%)	19 (86.4%)
Timing of next birth discussed	2 (9.1%)	20 (90.9%)
Current pregnancy status discussed	7 (31.8%)	15 (68.2%)
History of pregnancy complications discussed	1 (4.5%)	21 (95.5%)
Partner's attitude about FP discussed	1 (4.5%)	21 (95.5%)
Multiple/single sexual partner discussed	4 (18.2%)	18 (81.8%)
HIV/AIDS and STIs discussed	6 (27.3%)	16 (72.7%)
History/signs/symptoms of STIs discussed	2 (9.1%)	20(90.9%)
Explained method does not protect against HIV/AIDS &STIs	1 (4.5%)	21 (95.5%)
Provider encouraged client to use condom as second method	1 (4.5%)	21(95.5%)

Table-4:con'd

Information how to use methods (n=3)		
Provider give accurate information how to use the method	2 (66.7%)	1 (33.3%)
Information on side effects of methods (n=8)		
Give accurate information about side effect of the method	2 (25.0%)	6 (75.0%)

6.3. Facility Audit

Official opening time for both HSDPs was 8 to11:30 Am in the morning and 4 to 5:30 PM in the afternoon from Monday to Friday during the data collection period. There was no sign of announcing that FP services are available in both HSDPs during the data collection period. There was no any IEC materials were made available for teaching clients on FP methods and STIs in the study health institutions. There was a separate room /area for physical examination in Hospital and privacy of examination room was ensured, but the Health centre was being used one unseparated room for all kind of services and Privacy of examination room was not ensured. Water and light were adequate in FP service delivery room, similarly waiting area also adequate for clients, however; there was no adequate water supply for clients and shortage of toilet facilities for both clients and staff in the studied health facility. Proper sharp disposal container was available and being used in the injection room, but proper waste disposal container was not available and being used in both HSDPs. Couches and tables were adequately available (two couch, seven chair and three tables at hospital, and one couch, three chair and one table at the health center under study) in both FP service delivery rooms. The service delivery room was found uncleaned, narrow and lacking in privacy in health centre. In the studied health institution FP products were free from rain, sun, extreme heat, rats and pest, and dusts, however; the commodities not stored according to expiration date. Daily FP activity register/logbook is available for recording multiple revisits or new clients, and daily FP service records were fully documented, however; Client records were not kept in secured area in both of the health service delivery points. Both HSDPs was sent monthly statistics report about FP services activity to higher unit, and the last report was sent before 3 months, however; feedback was not received on report. Recently there was no supervisor come there in relation to FP services. Generally there were 4 Diploma Nurses (3 males and 1 female) to provided FP services and 2 of them were assigned at each HSDPs while only one clinical service providers usually available to provide the service at a time.

The contraceptive methods available in both HSDPs were Injectable, pills and condoms while Norplant were available only in hospital. Method used to have information about client opinion was not available in the studied health facility, and there were no stock out of all contraceptive supplies except condom in which its frequent shortage was reported during the study period. Blood pressure apparatus, weight scale, uterine sound, antiseptic solution, disposable gloves, thermometer, needle & syringe and mini lap kits were available and functional while sterilizer, flash light, speculum, scissors, autoclave and minor surgery equipments were not available in family planning service department in both HSDPs. None of the HSDPs had Copy of MOH guideline of family planning services in Ethiopia.

6.4. In-depth Interview

A total of 6 service providers, 3 from each FP service delivery points were interviewed and responded to the questions, while Regional FP coordinator were not available at the time of data collection period. Four of service providers were Diploma nurses and two was pharmacist. The average service year in family planning program was 1.8 years with range of 1 to 3 years. Only 2 of the providers had basic training on how to insert and remove Norplant and others had no any basic training on family planning. Two of the respondents who had the training said that the basic training was inadequate in performing all components of family planning services, because the training was not included all components of contraceptive methods and only focused on theoretical part and not practiced on real clients. All providers responded that there were only four contraceptive methods available including condom out of them the most of the clients were interested in pills second to that of Depo-Provera while emergency contraceptives were not available. On the problem which is beyond their capacity, they replied for referral of clients to higher health institution. Two of the provider said that since there was a shortage of surgical glove for insertion and removal of Norplant, sometimes the clients were in forced to buy surgical glove and shared some of other equipment like scissors, forceps and surgical blade from gynecology department. Finally, all family planning service providers were asked about the current existing problems. Acute shortage of different contraceptive methods and unavailability of some Logistics, lack of trained/skilled staff and translators, absence of close supervision and lack of attention by higher managers were the common problem all providers complained and being seen in family planning department in the studied health institution.

Chapter seven: Discussion

This study identified major constraints in family planning service delivery points in Gambella town public health facilities which were related to quality of care in family planning services. Only female clients were available during data collection period. Young women who were 20-29 years old were high contraceptive users, 248 (58.8%). This was higher than studies conducted in Gondar, North West Ethiopia which was 123 (45.6%). About 379 (89.8%) of the clients were married. The likely reason for this high percentage of married women could be due to regular sexual contact with their husband and to avoid unplanned pregnancy. Secondly, married women were not influenced by cultures and they can utilize contraceptive methods anywhere freely.

Most family planning service users, 144 (34.1%), completed primary school, 97 (23%) of the respondents were attended secondary schooling (8-12) and the rest, 58 (13.7%) of the respondents were also attended twelve and above schooling. The probable reason for this large figures of educated clients might be due to educated clients were more likely conscious about the importance of contraceptive and interested to utilize family planning method than those uneducated clients.

Although, the common ethnic groups residing in the Region are Agnuak and Nuer, there was only small number, 54 (12.8%), and 26 (6.2%), who utilized family planning services respectively. The probable reason for observed gap was due to presence of language barriers between client and service provider during consultation session and lack of translator to local language in the family planning department at the same time as the providers recommended during in-depth interview. This should be assured that, the number of these ethnic groups who utilized ANC services were significantly large in their numbers than those who utilized family planning services.

The encouraging finding of this study showed that, 399 (94.5%) of clients were satisfied with opening hours of HSDPs. Majority, 394 (93.4%), of clients responded that waiting time was reasonably short. Similarly, 420 (99.5%) of clients were satisfied with waiting time to get the service. Most, 250 (59.2%) of clients were responded that the average waiting time was 16-30 minutes, whereas 115(27.3%) of clients were responded that the average waiting time to get service was less than 15 minutes. The waiting time observed in this study was less than studies in Jimma (31.7 minutes) (36) and Bangladesh (30minutes) (47). Therefore reasonable and short waiting time was recognized in this study. Similar study was also reported in Kenya (37, 48).

Researchers also have shown that reasonable and short waiting time is a principal factor leading to high rate of service satisfaction and method continuation (49). Form this study; the median consultation time was 2.5 minutes. This was similar to studies conducted in Jimma and Bangladesh where the average consultation time was (3.1, 2.3 minutes) respectively (36 46).

The proportion of clients who expressed dissatisfaction with information provided to them on the method was very large, 292(69.2%). Of 355 continuing clients, 91 (25.6%) of them reported problems with the method they received out of which only 50 (54.9%) of them were satisfied with solutions given to resolve their problem by the provider. Additionally only 78(18.6%) of clients were informed and described about possible side effect of the method, which was consistent with the outcome of client-provider interaction observation, that only in 2(25%) of cases clients were given information on side effect of method and lack of basic training on relevant methods as all providers complained during in depth interview. Study conducted in East Show Zone, Oromia Regional State, was also indicated that providers did not discuss with clients on the side effect of the specific family planning methods they took (67.7%) (34).This could reflect low technical competence and/or low counseling skills of service providers in problem solving. Such incapability to resolve common side effects of the method could be the factors associated with service switching or discontinuation use of family planning services completely, as revealed in the study conducted in Kenya (45).

The most commonly used family planning method was found the injectable, 351 (83.8%), followed by pills, 65 (15.4%). The type of family planning method received is influenced, among other things, by knowledge about family planning methods and the availability and acceptability of the method by those who use the services. In this study, the injectable appears to be the most preferred family planning method perhaps because of its long term effect. In the injectable, there is no need to worry about remembering to use it daily or when somebody has sexual intercourse. The method also avoids frequent visits to health institutions for supplies. Studies have shown that use of injectable has been progressively growing in sub-Saharan Africa (41, 42, and 43). Of particular interest in these studies were the higher levels of use of injectable among women. The preference of women for injectable contraceptives indicates the need to make it available and accessible to the clients. The introduction of injectable has highly improved family planning coverage in Zimbabwe (43). In this study, the injectable and the pills were the most commonly discussed methods to new clients by the providers which may give clients restricted choices.

Unavailability of clients' choice and not allowing informed choice might lead to client dissatisfaction and complete discontinuation. The condom, which is the most important method of "Dual Protection" against unplanned pregnancy and STIs/HIV/AIDS, appears to get less attention. No discussion was made concerning permanent methods of contraception in studied health institutions. But studies in India (51), Kenya (48) permanent method was popular and used by majority of clients. The probable reason for low use in this study might be shortage of trained staffs, unavailability of methods, and inadequate information given to clients. It seems that efficient and effective methods for limiting the number of children (stopping child bearing) are neglected and those who need them may not be aware of the possibility of having such chances.

Majority of clients, 107 (33.6 %), were breast-fed at the time of data collection but none of them were encouraged to use lactation amenorrhea method. Emergency contraception and Natural method were not available and discussed with none of clients. This might show that most service providers were not able to advised clients and not considering its importance and practicability, whereas thus potential clients would not be able to know about it and use it. This is consistent with the study conducted in Gondar, North West Ethiopia (35). About 413 (99.0%) of family planning users in this study chose the methods themselves and 412 (98.1%) of them was received their method of choices which is consistent with the result of observation that all of new clients stated their methods of choices & all were received. This is apparently shows the appropriateness of providing the services and that it should be extended to all users. Such practice is expected to increase satisfaction and sustained use. A focus of consideration at this point is that allowing clients to choose a method is useful only when the client has adequate & quality information on all the relevant methods.

In general this study shows that a high proportion of the respondents, 362 (85.8%), have found the health service providers easy to understand, and 249(59.0%) of clients were comfortable to ask question during counseling. Almost all of the respondents, 388 (91.9%), were well treated by the provider during their visit. Similarly, 347(82.2%) of the respondents in this study were also satisfied with maintenance of privacy. Privacy is one of the main criteria required for assessing quality of care (22). The presence of privacy could be one of the major assist for initiating and continuing of family planning service users. During client provider interaction a great majority of the clients, 20(90.9%), were not asked about history/signs/symptoms of STI and related risks. Similarly, multiple/single sexual partner were not discussed in18 (81.8%) of cases, and provider not explained method does not

protect against HIV/AIDS &STIs, while only in 1(4.5%) of cases clients were encouraged /advised to use condoms as a second methods.

This was consistent with the result observed in client exit interview in which 124(29.4%) of client were not discussed about HIV/AIDS &STIs and only 135(32.0%) of clients were advised to use condoms as a second methods. Similar with the study conducted in Gondar, northwest Ethiopia, about (98.5%) of the clients were not asked about STD risk and only (3.0%) of the respondents were advised to use condoms (35). Thus in Ethiopia, which is one of the hardest hit countries by HIV/AIDS in the world & the third in the number of HIV infected people in sub-Saharan Africa (44) such an opportunity is, thus, missed for HIV/AIDS prevention & control.

The great proportion, 398 (94.3%), of clients were reported dissatisfaction with the availability of adequate water supply at waiting area while 292 (69.2%) of clients were expressed satisfaction with ease of use toilet around waiting area. Majority, 301(71.3%), of the clients were satisfied with welcoming and respect of provider however; 244(57.8%) of the respondents were not satisfied with perceived competency of provider. The proportion of clients who expressed satisfaction with perceived empathy was 280(66.4%), while 291 (69.0%) of client were dissatisfied with counseling provided to them. Inadequate competency of providers is one of the main observed gaps in this finding, which significantly influenced acceptability of service, satisfaction and continuity of family planning service users. All of clients were informed when to return for follow-up visit and granted with reminder cards, as well as almost all, 418(99.1%), of clients were responded that they will come back for the next appointment. This is consistent with the outcome of observation in all cases providers discussed a return visit & given with written reminder cards for follow up visit.

A sign announcing the availability of family planning services was not posted in both of health service delivery points during the data collection period. Studies in Addis Ababa showed that a sign announcing the availability of family planning services were posted in more than half of the health institutions which is far better than this study (37). Signs of announcing availability of family planning services were displayed in 52% and 11% of health service delivery points in Nigeria and Tanzania respectively (52). Unavailability of posting sign of announcement can decrease popularity, and clients might not be aware of the availability of family planning service. Even though the waiting areas for clients in both family planning service delivery points were adequate, it was not provided with adequate and accessible water supply and latrine.

Both family planning service delivery points had monthly statistical reports on family planning service activities, but supervisions from higher institutions with regular supervisory visit were not common.

Inadequate supervision was also documented in Jimma where all health service delivery points had not received supervisory visit within three months prior to data collection time (36). Poor supervision was reported in some African countries like Burkina Faso (50), and Nigeria (52). Strong supervision and control system can help to strengthen and maintain good quality of care. All the above conditions can have an effect on continuity mechanism in quality of care. For instance, as study done in Tanzania, it was one of the factors that improved quality of care in family planning services (54).

At the time of facility audit there was no any IEC materials made available for teaching clients on family planning methods and STIs in the study health institutions. Client-provider interactions observation also revealed that no IEC materials were used while informing, communicating or counseling clients. The probable reason for these gaps might be lack of awareness or underestimating the importance of IEC materials among service providers. Studies in Burkina Faso (50), Nigeria, Tanzania, and Zimbabwe (52) had shown that IEC materials were not widely available. However, studies in Latin America showed that broad range of IEC materials were used to disseminate information (53). Information, education, and communication materials are important source to disseminate information, especially where there is shortage of trained staffs like Gambella town, which is the site for this study. However, ineffective IEC and counseling may result in frustration, discontinuation and method failure with all its consequences.

All the service providers who participated in this study had no basic training on family planning except two providers had basic training on how to insert and remove Norplant. All of the providers complained that absence of trained staffs and basic training on family planning services were one of the main gaps observed in the family planning service department and obstacle to provide quality of care. Due to shortage of manpower they were providing family planning service by shifting in addition to other outpatient activities. Inadequate training was also reported in other countries like Tanzania, 41%, in Zimbabwe 30%, and in Nigeria 6% of service delivery points had no trained staffs (52). Further assessments on the reasons for the claim were not done in this study. It is thus important to further explore this issue for possible improvement in the basic training of health workers.

Since the in-service training was generally not conducted for most of the providers there is little opportunity for the health workers to get up to date information on current concepts and practices.

The copy of MOH guideline of FP services in Ethiopia was not available and to be used at both levels of HSDPs but it is clear that in the absence of the guideline, implementation of the stated objectives and principles for the improvement of quality would be difficult.

Generally in this study the overall clients' satisfaction with family planning service provision was found to be 257 (60.9%). This is higher than the study conducted in Dale Woreda Sidama Zone in which about 152(44.6%) of clients were satisfied with the service delivery process (55).

7.1. Strengths and Limitation of the study

Strength of the study

- Using both quantitative and qualitative (triangulation) data collection method from different sources to increase the validity of study and produce precise result.

Limitations of the study

- Since the study was institutional based might underestimate the results related to satisfactions. It is possible that dissatisfied clients might not come to health institution.
- Social desirability bias [Providers might show the best performance & perhaps users might also show courtesy bias during the exit interview].
- The prepared tools not sufficient to evaluate all components of quality.

7.2. Conclusions

This study revealed several constraints in the provision of FP services with improved quality of care, which can be implied as area of possible improvement

1. Majority of family planning service users were satisfied with the service provided to them.
2. Even though the service providers showed empathy to greater clients, limited number of clients got information on the side effect of the methods and others.
3. Because of unavailability of all contraceptive methods and other supplies, choices were generally limited to only specific methods like injectables and pills, while long term and permanent methods, natural methods and emergency contraception were not available at all.
4. Lack of trained man power and absence of translators might result in poor competency, inability of counseling and problem solving skills and inadequate information about specific methods and their side effects.
5. Absence of IEC materials for teaching clients on family planning methods was the observed constraints to improve quality of care in family planning service.
6. Absence of copy of MOH guideline of FP services in Ethiopia would make the implementation of the stated objectives and principles difficult for the improvement of quality of care in family planning services.
7. Lack of regular supervisory visit by higher unit and absence of mechanism to make programmatic change based on clients' feedback.
8. Shortage of adequate water supply and toilet facilities for staffs and clients separately.

7.3. Recommendation

Based on the above findings, the following recommendations are given:

1. Efforts must be made by the RHB and service providers to fully satisfy all family planning service users.
2. Information provision to the clients on the side effect of the methods and others relevant issues should be emphasized by service providers.
3. Special attention should be given to avail all relevant family planning methods and other supplies which help to reduce restricted choice of users to specific methods.
4. Recruiting or increasing number of qualified staffs' and assigning trained translator.
5. Providers' special training, with task oriented refreshment course, special emphasis on strengthening providers' technical competency, problem solving ability, communication and counseling techniques.
6. Improving the availability of IEC materials for service provision.
7. Improving program management capacity at all levels, considering the need for mechanism to make programmatic change based on clients' feedback and regular supervision by higher unit.
8. Making available copy of MOH guideline of FP services in Ethiopia for service providers.
9. Improving provision of adequate water supply and toilet facility for staffs and clients separately.

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Annexes

Annex I- Sample English Questionnaire for Exit interview

Jimma University

College of Public Health and Medical science Department of Community Health

Consent Form for client exit interview:

Title: - Assessment of Quality of care in Family Planning services in Gambella Town public health facilities, Gambella regional State, Southwest Ethiopia.

To be filled by data collectors:

Region______________ Zone _____________ Woreda______________

Cod number of the health institution______________

Good morning dear client! My name is ____________. I came from Gambella Regional health bureau. I am a member of research team on assessment of quality of family planning service, which is going to be carried out by Jimma University. It is believed that quality family planning service increases clients' satisfaction, which contributes to increase contraceptive prevalence rate. The purpose of this study is to assess the quality of family planning service provided in some public health institutions and finally to give important comment that will help to strengthen and improve quality of family planning service. We would like to improve the quality of family planning service provided by this clinic. To do this, your information is very important. I would like to ask you a few questions about your visit to the clinic to find out your experience today. We would be very grateful if you could spend a few minutes to answer questions related to the service. We will not put your name or registration number in the format. All the information you give will be kept strictly confidential. Your participation is voluntary and you are not obliged to answer any questions you do not want. However, your honest participation will contribute to generate information that can be used to improve quality of care in family planning service.

Do I have your permission to continue? Yes ☐ No ☐

Code number of the client ------------ Client arrived at service delivery points--------

Time client received service------- Waiting time------------------

Interviewer: -Name____ Cod number _______ Cheeked by supervisor/investigator. Signature__

PART I: Session I Socio – Background characteristics

No	Questions & filter	Coding category	Skip to
101	How old are you?	1.Age in years ------ 88. Don't Know 99. No answer	
102	Your residence	1. Rural 2. Town	
103	What is your current marital status?	1. Single 2. Married 3. Divorced. 4. Widowed 99. No answer	
104	If married /have regular partner, have you discussed family planning with your husband?	1.Yes 2.No 88. Don't remember	
105	Do you have children?	1. Yes 2. No---------------------	Q111
106	If yes, how many living children do you have?	1.One 2.Two 3.Three 4. Four 5. Five & above	
107	What is the age of your youngest child?	1. ------Year/Month------- 88. Don't know	
108	Would you like to have more children?	1. Yes 2. No 99. No answer	
109	If yes, when would you like to have the next child?	1. Immediately 2. Up to 1 year 3. Up to 2 years 4. Up to 3 years 5. After 3 years 99. No answer	
110	Are you currently breastfeeding?	1. Yes 2. No	
111	What is your educational level?	1.Illitrate 2. Write & read only 3. Primary school(1-8) 4.Secondaryschool completed(9-12) 5.Tweleve +1& above	
112	What is your religion?	1. Orthodox 2. Christian-Protestant 3. Muslim 4. Catholic	

		5.Other (Specify)-------	
113	What is your ethnicity?	1. Agnuhak 2. Nuer 3. Mezhenger 4. Oromo 5. Kembata 6. Gurage 7. Tigre 8. Amhara 9 .Other (specify)----	
114	What is your occupation	1.Government employee 2.Private employee 3.Merchant 4.Un employed 5.House wife 6.Student 7.Daily laborer 8.Prostitute 9.Other (specify)------	
115	What is your monthly income?	---------------Eth. Birr	
116	How long did it take to you to arrive at this clinic?	1. Less than half hrs 2. Half to 1 hrs 3. More than 1 hrs 4. More than 2 hrs	

PART- I SESSION II: Client exit interview on service delivery (For both new and repeat)

No	QUESTION	RESPONSE	Skip to
117	Have you ever visited this site for Family planning services before today	1-Yes 2- No	
118	What was the reason for your visit today?	1- **Get information and/or counseling** about a contraceptive method 2- **Receive, get prescribed or referred** for a contraceptive method for the first time or for the first time at this site 3- **Restart** contraceptive method use (after not using for 6 months or more)	125
		4- **Get supplies** for method already using or have a routine follow-up visit for method already using 5- **Restart same method** (after not using for less than 6 months) 6- **Switch** contraceptive methods **or restart a different method** (after not using for less than 6 months) 7- **Discuss a problem** about contraceptive method that you are currently using	119
		8- **Other**, non family planning-----------------	135
119	What contraceptive method are you using/were you last using (in the past 6 months)?	1- Pill 2- IUD 3- Inject able 4- NORPLANT 5- Female sterilization 6- Condom	

		7- Spermicidal 8- Diaphragm 9- Condom + other methods 10- Other specify------------- 88-I don't know	
120	Did the provider ask if you were having a problem with the method	1- Yes 2- No	
121	Have you had a problem with your method	1- Yes 2- No ---------------------	125
122	Did the provider try to understand the nature of your problem?	1- Yes 2- No	
123	Did the provider suggest what you should do (action you should take) to resolve the problem?	1- Yes 2- No	
124	Were you satisfied with the advice or treatment that you received for your problem?	1- Yes 2- No	
125	Did you come here today to obtain a specific contraceptive method?	1- Yes 2- No-------------------------------	127

126	Which method did you want when you came here? /Before your consultation, did you have a specific method in mind? /	1. Pill 2. IUD 3. Inject able 4. NORPLANT 5. Female sterilization 6. Condom 7. Spermicidal 8. Diaphragm 9. Condom + other methods 10. Other specify------------- 88-I don't know	
127	Which methods did the provider discuss with you	1. Pill 2. IUD 3. Inject able 4. NORPLANT 5. Female sterilization 6. Condom 7. Spermicidal 8. Diaphragm 9. Condom + other methods 10. Other specify------------- 88-I don't know	
128	Did you receive a contraceptive method today?	1- Yes----------------------------------- 2- No	130
129	Were you given a prescription or a referral for a method today	1- Yes, prescribed a method 2- Yes, referred for a method 3- No (but a method was named in 127)--------- 4- No (no method was named in 127)------------	131 135

130	Which method(s) did you receive or were you given a prescription or a referral	1. Pill 2. IUD 3. Inject able 4. NORPLANT® 5. Female Sterilization 6. Condom 7. spermicidal 8. Diaphragm 9. Condom + other method 10. Other__________________	
131	**To be answered by the interviewer**. Did the client receive her method of choice? (Check questions #126 and #130.) Is the method named in #126 and #130 the same?	1- Yes (client did receive her/his method of Choice 2- Client had no preference 3- No (client did not receive her method of choice---	133 132
132	Why do you think you did not get (Method named in #126)?	1. Chose not to accept a method at this time 2. Preferred method was not appropriate (contraindications) 3. Provider recommended another method 4. Changed mind after listening to provider 5. Not available at clinic today 6. Not available at all 7. Not available, referred to another source 8. No appropriate provider available that day 9. Other (specify) -------------	

(Ask # 133 and # 134 only if the method is received/ prescribed/ referred). If NO method is received/ prescribed/ referred, go to #135				
133	**For the method you just decided to accept, did the provider:**			
133.1	Explain to you how to use the method effectively?	1- Yes 2- No 88- Don't know/ can't remember		
133.2	Describe possible side effects	1- Yes 2- No 88- Don't know/ can't remember		
133.3	Tell you what to do if you have any problems	1- Yes 2- No 88- Don't know/ can't remember		
133.4	Explain that this method does not Provide protection against STIs and AIDS Do not ask if method = condoms	1- Yes 2- No 88- Don't know/ can't remember 99- Not applicable *(*method = condoms*)*		
134	**Circle the method(s) received/ prescribed/ referred in #130 and asks the question(s) that correspond to the method(s).**			
134.1	Pill	How often do you take the pill?	1- Take the pill once a day 2- Other 88. Don't know	
134.2	IUD	What should you do to make sure that your IUD is in place?	1- Check strings 2- Other 88- Don't know	
134.3	Inject able	How long does the Inject able provide protection against pregnancy?	1- 3 months 2- Other 88- Don't know	

134.4	NORPLANT	How long does NORPLANT provide protection against pregnancy?	1- 5 years 2- Other 88. Don't know	
134.5	Female Sterilization	Once you have been sterilized, could you ever become pregnant again	1- No 2- Other 88- Don't know	
134.6	Condom (male or female)	How many times can you use a condom?	1- Once 2- Other 88- Don't know	
134.7	Spermicidal	Approximately, how long before intercourse should you insert the vaginal tablet?	1- Between 15 minutes and hours 2- Other 88- Don't know	
134.8	Diaphragm	Approximately how long after intercourse should the diaphragm remain in place	1- At least six hours (but no longer than 24 hours) 2- Other 88- Don't know	
135	Were you told when to return for a follow-up visit		1-Yes 2-No 88- Don't know/can't rambler	
136	Did you feel comfortable to ask questions during the counseling session?		1- Yes 2. No 88- Don't know	
137	Do you feel the information given to you during your visit today was too little, too much, or just about right?		1. Too little 2. About right 3. Too much 88- Don't know	
138	Did you have a pelvic exam during your visit today?		1- Yes 2- No------------------------	140

139	Did you have enough privacy during your exam? /Clients or staff, other than those caring for you, could not see you. /	1-Yes 2-No 88- Don't know/ can't remember	
140	When meeting with the provider during your visit, do you think other clients could hear what you said?	1- Yes 2- No 88- Don't know	
141	Do you believe that the information that you shared about yourself with the provider will be kept confidential	1- Yes 2- No 88- Don't know	
142	During your visit to the clinic how were you treated by the provider	1- Very well 2. Well 2- Not very well/ poorly	
143	During your visit to the clinic how were you treated by the other staff	1- Very well 2- Well 2- Not very well/ poorly 3- There was no other staff	
144	Are the opening hours for this clinic convenient for you?	1. Yes 2. No 88. Don't know the opening hours 99. No answer	
145	About how long did you wait between the time you first arrived at this clinic and the time you saw a staff person for a family planning consultation?	1. <15minutes 2. 16-30 minutes 3. 31-45 minutes 4. 46-60 minutes 5. 61-90 minutes 6. 91-120 minutes 88. Don't know	
146	Do you feel that your waiting time was reasonable or too long?	1. No waiting time 2. Reasonable/ short 3. Too long 88. Don't know	

147	During your talk with the provider, was STIs/AIDS discussed	1-Yes 2-No 88-Don't know/ can't remember	
148	Did the provider encourage you to use condoms at the same time simultaneously) as the family planning method, you chose or are currently using? Do not ask if method = condoms	1-Yes 2-No 88-Do not know/ can't remember 99. Not applicable (method = condoms	
149	Did you feel that your consultation with the clinical staff was	1. About right 2. Too long 3. Too short 88. Don't know 99. No answer	
150	During consultation, was the provider easy to understand	1. Easy to understand 2. Difficult to understand 3. Don't understand 99. No answer	
151	Did you pay for the service and for Contraceptive	1. Yes 2. No	
152	If yes how much for one visit?	1. Price for contraceptive per cycle 2. Price for service _______	
153	Did the service provider tell You when to come back?	1. Yes 2. No 88. Don't know 99. No answer	
154	Will you come back for next appointment?	1. Yes 2. No 88. Don't know 99. No answer	

Part I Section III. Miscellaneous scale on client satisfaction

Statements that measures client satisfaction on family planning service provision.

Please mark (/) according to your agreement in the statement, i.e. if they are strongly disagree mark (/), if they are disagree mark (/), if they are between disagree and agree mark (/) if they are agree mark (/) and if they are strongly agree mark (/) on the space provided.

No	*Statement*	*1 Strongly Disagree*	*2 Disagree*	*3 Neutral*	**4 Agree**	*5 Strongly Agree*
155	Opening time is convenient for you					
156	Provider greeting is good and in a friendly way					
157	Provider perform the procedure with cleanliness and sanitation					
158	Provider has good knowledge and skill to perform the procedure					
159	Counseling was clear & satisfactory					
160	Sufficient methods are available					
161	Information given about the method is sufficient					
162	Waiting time is satisfactory					
163	Privacy was maintained					
164	Waiting place is adequate with water supply					
165	Waiting place is adequate with latrine					

Annex II- Sample Checklists for observation

Title: - Assessment of Quality of care in Family Planning services in Gambella Town public health facilities, Gambella regional State, Southwest Ethiopia.

Consent Form for Observation of provider client interaction

Code number of the health institution______________________

Greet providers and clients; introduce yourself and the purpose of the study.

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

Good morning dear provider and client!

My name is ----------------------------. I came from Gambella Regional Health Bureau. I am a member of research team on quality of family planning service, which is going to be conducted by Jimma University.

It is believed that quality family planning service increases contraceptive prevalence rate and the purpose of this study is to assess quality of care in family planning service in public health facilities. The finding of this study is intended to improve quality of care in family planning service in both Governmental and non-governmental health institutions and hence to increase contraceptive prevalence rate. For this study, you are chosen to participate.

The observation includes various techniques to evaluate your interaction. In order to attain effectively the goal of this study, I am asking you for your generous participation. I do not put your name or registration number on this questionnaire. It is your full right to refuse or participate in the study. However, your honest response will contribute to generate information, which can be used to improve quality of care in family planning service.

Do you agree to participate in this study?

Yes ☐ No ☐ Code ID Number of the client_____________

No	Questions & filter	Coding category	Skip to
1.	Sex of provider	1-Male 2- Female	
2.	Did the provider		
2.1.	Greet client	1- Yes 2- No	
2.2	Ask open-ended questions	1.Yes 2.No	
2.3	Encourage client to ask questions	1. Yes 2. No	
2.4	Treat client with respect	1- Yes 2- No	
2.5	See client in private	1- Yes 2- No	
2.6	Discuss a return visit	1- Yes 2- No	
2.7	Was the client told when to return for re supply	1- Yes 2- No	
2.8	If yes, did the provider give to the client some form of written reminder	1- Yes 2- No	
2.9	Ask client her concerns with any method	1. Yes 2. No	
2.10	Use visual aids	1. Yes 2. No	
2.11	Use client record	1- Yes 2- No	
2.12	Assure client of confidentiality	1- Yes 2- No	
3	**Is the following Information Discussed during counseling session:**	**Coding category**	**Skip to**
3.1	Current age	1- Yes 2- No	
3.2	Current Marital /relationship/ status	1-Yes 2- No	
3.3	Number of living children	1-Yes 2- No	
3.4	Desire for more children	1- Yes 2- No	
3.5	Timing of next child	1- Yes 2- No	
3.6	Current pregnancy status	1- Yes 2- No	
3.7	History of pregnancy complications	1- Yes 2- No	
3.8	Partner's attitude about FP (approve/disapprove)	1-Yes 2-No	
3.9	Multiple /single sexual partner(s)	1- Yes 2-No	
3.10	HIV/AIDS and STIs discussed	1-Yes 2- No	
3.11	History/signs/symptoms of STIs	1-Yes 2-No	
4	**Circle Method actually received / prescribed (new clients) or (continuing clients):**		
	1. Pills	5. Female sterilization	
	2. Condom	6. Diaphragm	

	3. IUCD 7. Nor plant			
	4. Spermicidal 8. Other/specify -------------			
5	**Client stated preference for method/only new clients**			
	1. Pill 6. Condom			
	2. IUD 7. Spermicidal			
	3. Inject able 8. Diaphragm			
	4. NORPLANT 9. No Preference---------------			Q # 9
	5. Female sterilization 10. Preference not discussed---------------			Q # 8
6	Preferred method received (for clients who state a preference)	1-yes----------------------------- 2-No----------------		Q # 8 Q # 7
7	Reason for clients not received preferred method	1. Not available in clinic that day 2. Not available at all 3. Not available, referred to another source or clinic 4. Not appropriate method (contraindications) 5. No appropriate provider available that day 6. Provider recommended another method 7. Changed mind after listening to provider 8. Client did not make choice at time of session 9. Client not at risk of pregnancy 10. Pregnancy suspected 11. Told to return during menses 12. Client could not pay for services today		
8	Provider determined client's reason for method selection	1- Yes 2-No		
9	**new clients by method received or prescribed**	**Circle the method that the client received or was prescribed and observe as appropriate**		
	1. Pill	1-Check Blood Pressure	1- Yes 2- No	
		2-Check/Ask Pregnancy	1- Yes 2- No	
		3-Ask About Smoking	1- Yes 2- No	

		4-Ask about Breastfeeding	1- Yes 2- No	
		5-Provide #condoms or Cycles	1-Yes 2-No	
	2. IUD	1-Check/Ask Pregnancy	1-Yes 2- No	
		2-Ask about Last Delivery Date	1-Yes 2-No	
	3. Inject able	1-Check Blood Pressure	1-yes 2-No	
		2-Check/Ask Pregnancy	1- Yes 2-No	
	4. NORPLANT	1-Check Blood Pressure	1- Yes 2- No	
		2-Check/Ask Pregnancy	1- Yes 2- No	
	5. Female Sterilization	1-Ask About Chronic Health Problems	1- Yes 2- No	
		2-Check/Ask Pregnancy	1- Yes 2- No	
	6. Condom	1-Provide #condoms or Cycles	1- Yes 2- No	
		2-Ask about Allergies to Latex	1-yes 2-No	
	7. Spermicidal	1-Ask about Pregnancy Complications	1-yes 2.No	
	8. Diaphragm	1-Ask about Last Delivery Date	1- Yes 2- No	
		2-Ask about Allergies to Latex	1- Yes 2- No	

Provider gave accurate information about key point: (See guidelines below)

10	How to use	1. Yes 2. No	
11	Side effects	1. Yes 2. No	

Contraceptive Methods Guidelines

NO	Method	**How to Use**	**Side Effects**
1	Pills	Must be taken every day	Nausea, spotting
2	IUD	Should check strings	Menstrual bleeding
3	Inject able	Provides protection for 3 months	Menstrual changes
4	NORPLANT	Provides protection for 5 years	Menstrual changes
5	Female Sterilization	Can never become pregnant again	Pain at surgical site
6	Condoms	Use once	Allergy to latex
7	Spermicidal	Must insert 15-60 min before intercourse	Tissue irritation
8	Diaphragm	Must leave in place 6hours after intercourse	Bladder infection

12	Did the provider Explain method does not protect against STIs and AIDS (skip if the method is condom)	1-Yes 2-No	
13	Did the provider Encourage use of condoms as 2nd method (skip if the method is condom)	1-Yes 2-No	
14	Clinical provider same person who provided counseling:	1-Same person 2-Different person	
15	Provider performing MOST of clinical examination:	1-Nurse 2-Nurse- Midwife 3-Doctor 4-Health Worker 5-Other _______	
16	Sex of Provider:	1-Female 2-Male	
17. Observation conducted for		**category**	**Remark**
A. Client received inject able – if yes, complete section A		1. Yes 2. No	
B. Client underwent pelvic exams – if yes, complete section B		1. Yes 2. No	
C. Client had an IUD inserted – if yes, complete section C		1. Yes 2. No	

For each item, observe and mark "yes," "no," or "N/A" (not applicable) as appropriate.

A. Injectables

NO	**Did the provider**	**Category**	
D-1	*(*NEW CLIENT*)* Reconfirm client's method Choice	1- Yes 2- No	**3-N/A**
D-2	*(*NEW CLIENT) Verify client is not pregnant	1- Yes 2- No	**3-N/A**
D-3	*(*CONTINUING CLIENT*)* Give injection at correct time	1- Yes 2- No	**3-N/A**
D-4	Wash hands before injections	1- Yes 2- No	**3-N/A**

D-5	*(If re-usable)* Use newly reprocessed needle and syringe	1- Yes 2- No	**3-N/A**
D-6	Stir/mix bottle before drawing dose	1- Yes 2- No	**3-N/A**
D-7	Clean and air-dry injection site before Injection	1- Yes 2- No	**3-N/A**
D-8	*(If gluteal)* Inject in upper outer quadrant	1- Yes 2- No	**3-N/A**
D-9	Draw back plunger before injection	1- Yes 2- No	**3-N/A**
D-10	Allow dose to self-disperse instead of Massaging	1- Yes 2- No	**3-N/A**
D-11	Dispose of sharps in puncture resistant Containers	1- Yes 2- No	**3-N/A**

B. Pelvic Exams

NO	**Did the provider:**	**Category**	
P-1	Ensure client has privacy	1- Yes 2- No	**3-N/A**
P-2	Prepare all instruments before exam	1- Yes 2- No	**3-N/A**
P-3	Wash hands before exam	1- Yes 2- No	**3-N/A**
P-4	Use sterilized or high-level disinfected instruments for each exam	1- Yes 2- No	**3-N/A**
P-5	Put on new or disinfected gloves before exam	1- Yes 2- No	**3-N/A**
P-6	Inspect the external genitalia	1- Yes 2- No	**3-N/A**
P-7	Ask the client to take slow, deep breaths, and relax all muscles	1- Yes 2- No	**3-N/A**
P-8	*(If used)* Explain speculum insertion procedure to client	1- Yes 2- No	**3-N/A**
P-9	Inspect the cervix and vaginal mucosa	1- Yes 2- No	**3-N/A**
P-10	Perform bimanual exam gently and without discomfort to client	1- Yes 2- No	**3-N/A**
P-11	Ensure that instruments and reusable gloves are decontaminated	1- Yes 2- No	**3-N/A**

C. IUCD Insertion

No	Did the provider:		**Category**
I-1	Ensure client has privacy	1- Yes 2- No	**3-N/A**
I-2	*(NEW CLIENT)* Reconfirm client's method choice	1- Yes 2- No	**3-N/A**
I-3	Use sterilized or high-level disinfected instruments	1- Yes 2- No	**3-N/A**
I-4	Wash hands before putting on gloves	1- Yes 2- No	**3-N/A**
I-5	Glove hands	1- Yes 2- No	**3-N/A**
I-6	Conduct speculum exam for RTI/STIs before bimanual exam	1- Yes 2- No	**3-N/A**
I-7	Conduct bimanual pelvic exam	1- Yes 2- No	**3-N/A**
I-8	Visualize cervix during cleaning	1- Yes 2- No	**3-N/A**
I-9	Use Teneculum	1- Yes 2- No	**3-N/A**
I-10	Sound the uterus before IUD insertion	1- Yes 2- No	**3-N/A**
I-11	Use the no-touch technique for inserting the IUD	1- Yes 2- No	**3-N/A**
I-12	Wash hands after removing gloves	1- Yes 2- No	**3-N/A**
I-13	Ask client to wait/rest for at least 15 minutes after insertion	1- Yes 2- No	**3-N/A**
I-14	Wipe contaminated surfaces with disinfectant	1- Yes 2- No	**3-N/A**
I-15	Ensure that instruments and reusable gloves are decontaminated	1- Yes 2- No	**3-N/A**

Date of visit ____________________ ID. Number of the client ______________

Name of observer ______________ Signature __________

Checked by supervisor/investigator Signature______________

Time Observed Session Ended (Use military time) _______

Annex III- Sample Checklist for Facility Audit

Title: - Assessment of Quality of care in Family Planning services in Gambella Town public health facilities, Gambella regional State, Southwest Ethiopia.

Consent form for facility audit:

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

Code No of health institution _____________ Date of visiting____________

Part-II Section I- Condition of the facility

	Question and filter	Coding category	remark
1	What is the official opening time for this Service delivery point?	_____	
2	How soon after the official opening time, were services provided?	________	
3	**Is** family planning service being provided on the day of the visit?	1. Yes 2. No	
4	Is there a sign announcing that family planning services are available	1. Yes 2. No	
5	Indicate the number of staff who provides family planning service at this service delivery point on the day of the visit	1.Doctor 2. Nurse who is female 3.Nurse who is male 4.Community based distributors 5. Other specifies___	
6	Which family planning IEC materials are available?	1. Posters 2.Flip Chart 3. Brochure/Pamphlet 4. Information Sheet	

		5. Job Aids 6. Counseling cards 7.Other(specify)____	
7	Is there a separate room or area for physical examination?	1. Yes 2. No	
8	Is the privacy of the examination room ensured	1. Yes 2. No	
9	Is there adequate light in the examination room?	1. Yes 2. No	
10	Is there adequate water supply in the examination room?	1. Yes 2. No	
11	Is there adequate waiting area for clients?	1. Yes 2. No	
12	.Is there adequate toilet	1. Yes 2. No	
13	Is the toilet provided separately for clients and staffs	1. Yes 2. No	
14	Is there adequate water supply for clients	1. Yes 2. No	
15	Is there adequate water supply for staffs	1. Yes 2. No	
16	Is there proper sharp disposal container in the examination room	1. Yes 2. No	
17	Is there proper waste disposal container in the examination room	1. Yes 2. No	
18	Is there proper waste disposal container in the waiting area?	1. Yes 2. No	
19	Is there adequate examination couch or table in examination room?	1. Yes 2. No	
20	Is there adequate tables in the examination room	1. Yes 2. No	
21	Are there adequate tables in the waiting area?	1. Yes 2. No	
22	Is the waiting area clean?	1. Yes 2. No	
23	Is the examination room is clean?	1. Yes 2. No	
24	Are family planning commodities stored according to their expiration date?	1. Yes 2. No	
25	Are facilities for storing contraceptives adequate in the following respect:		
25.1	Products are free from rain	1. Yes 2. NO	
25.2	Products are free from sun	1. Yes 2. NO	
25.3	Products are protected from rats and pests	1. Yes 2. No	
25.4	Products protected from extreme heat	1. Yes 2. No	

25.5	Products protected from dusts	1. Yes 2. No	
RECORD KEEPING AND REPORTING			
26	Is there a client record card for recording multiple visits or new card issued for each visit?	1. Yes 2. No	
27	Is client records are kept in a secure area?	1. Yes 2. No	
28	Is there a daily family planning activity register /logbook?	1. Yes 2. No	
29	A daily family planning service records are	1-Fully documented 2-Partially documented 3-Not documented at all	
30	Is there monthly statistic reports about family planning activity sent to a supervisor or higher unit?	1. Yes 2. No	
31	IF YES, when was the last report sent	___________	
32	Is feedback received on reports	1. Yes 2. No	
33	When was the last time a supervisor come here in relation to family planning?	1. Yes 2. No	
34	How many clinical service providers are usually available to see family planning clients?	In Numbers______	
35	Is there any method used to have information about client opinions?	1. Yes 2. No	
36	IF YES, What methods do you have for determining client opinions?	1. Client suggestion box 2. Provider asks client 3. Other staff asks client 4. Other 5. No method available	

Part-II Section II -Equipment and Commodities Inventory

1. **Which of the following contraceptive methods are provided at this facility?**

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

(Observe and Ask)

NO	Type of Contraceptive Methods Usually Provides at this clinic	
37	COMBINED PILLS	1. Yes 2. No
38	PROGESTERONE ONLY PILL	1. Yes 2. No
39	IUD	1. Yes 2. No
40	INJECTABLES	1. Yes 2. No
41	CONDOMS	1.Yes 2.No
42	SPERMICIDE	1. Yes 2.No
43	DIAPHRAGM	1.Yes 2.No
44	OTHER (specify)____	1.Yes 2.No

2. **Which of the following types of equipment are available and in working order?**

How many types of equipments are available in the service delivery point and/or in the stockroom for family planning, services (mention the available equipments)

(Observe and Ask)

NO	Type of equipments	Available	Quantity	Functionality	Quantity
45	Sterilizer	1-yes 2-No		1-yes 2-No	
46	Blood pressure apparatus	1-yes 2-No		1-yes 2-No	
47	Weight Scale	1-yes 2-No		1-yes 2-No	
48	Flash light	1-yes 2-No		1-yes 2-No	
49	Uterine sound	1-yes 2-No		1-yes 2-No	
50	Speculum	1-yes 2-No		1-yes 2-No	
51	Scissors	1-yes 2-No		1-yes 2-No	

52	Teneculum	1-yes 2-No		1-yes 2-No	
53	Antiseptic solutions	1-yes 2-No		1-yes 2-No	
54	Disposable gloves	1-yes 2-No		1-yes 2-No	
55	Examination table	1-yes 2-No		1-yes 2-No	
56	Thermometer	1-yes 2-No		1-yes 2-No	
57	Needle and syringe	1-yes 2-No		1-yes 2-No	
58	Mini lap kits	1-yes 2-No		1-yes 2-No	
59	Sterile gloves	1-yes 2-No		1-yes 2-No	
60	Pregnancy test	1-yes 2-No		1-yes 2-No	
61	Disposable needles and syringes	1-yes 2-No		1-yes 2-No	
62	Autoclave	1-yes 2-No		1-yes 2-No	
63	Minor surgery equipments	1-yes 2-No		1-yes 2-No	
64	copy of MOH guideline of FP service in Ethiopia	1-yes 2-No		1-yes 2-No	
65	Disposal containers for contaminated waste/supplies	1-yes 2-No		1-yes 2-No	
66	Sharps containers for used sharps	1-yes 2-No		1-yes 2-No	
67	Plastic buckets or containers for decontamination	1-yes 2-No		1-yes 2-No	
68	Clean instrument containers	1-yes 2-No		1-yes 2-No	

This is the end. Thank you!

Annex IV- Sample checklists for in-depth interview

Title: - Assessment of Quality of care in Family Planning services in Gambella Town public health facility, Gambella regional State, Southwest Ethiopia.

Consent Form for in-depth interview

Health institution – Hospital ☐ Health centre ☐ Code of the health institution ☐

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

May I continue?

Yes ☐ No ☐ **Thank you!**

Cod of the service provider ______ Sex ____Age ____marital status___

Educational status__

1. How long have you been working here? ___________
2. For how many years have you been providing family planning service? ___________
3. What kind of training have you ever attended? /on Job training/
4. Do you think that the training you have received in FP is adequate to perform your duties? If no why explain?
5. Which methods of family planning should be given priority and should be improved?
6. Are all the necessary supplies and equipments for deliveries of family planning services are available at this facility? If not why? explain
7. What are the main problems regarding to family planning services and supply in your institution?
8. What are the main problems regarding to manpower for family planning services provision in your institution?
9. If a family planning client has a problem, which is beyond the capacity of the institution or if the method the client desired is not available in the institution what measure, you are taking
10. List the basic problem of this clinic and what should be improved to assured quality of care in FP services?

Annex V- Sample Amharic Questionnaire for exit interview

በመረጃ ሰብሳቢ¨ › ¾ሚሞላ

❖ የቤተሰብ ምጣኔ ተጠቃሚ:

መለÁ ኮÉ ቁØር________________

የደረሱበት ሰዓት_________________

አገልግሎት ያገኙበት ሰዓት________ጠቅላላ የቆዩበት ሰዓት__________________

¾ቃለ መÖÃቅ አድርጊው ስም______________________________መለÁ ኮÉ ቁØር____
______ ቃለመጠይቁን ያረጋገጠው ሱፐርቫይዘር /አጥኚ ስምና ፊርማ________________
______

¡õል 1:- ማህበራዊ መረጃችን በተመለከተ የሚቀርብ መጠይቅ::

ተ.ቁ	ጥያቄና ማጣሪያ	የመልስ አማራጭና መለያ ኮድ ቁጥር	Å²ለል
101	ክÉሜ ስንት ነው	1 ዕድሜ በዓመት____________. 88. አላውቀውም 99. መልስ አልተሰጠም	
102	ነዋሪነት የት ነው	1. ÑÖር 2. ከተማ	
103	የጋብቻ ሁኔ•	1-ያላገባች 4-ከባሏ የተፋች 2-ያገባችና አብራ የምትኖር 5-ባሏ የሞተባት 3-ያገባች ግን አብራ የማትኖር 99. መልስ አልተ›ö በ	
104	ያገቡ ከሆነ ስለ ቤተሰብ ምጣኔ ከባለቤት Òር ተነጋግረው ያውቃሉ	1. አ 2. የለም 88. አላስታ¨ ›ስም	
105	ልጆች አሉት	1. አ 2. የለኝም_______.	¨ Å Ø.ቁ 111
106	ልጆች ካሉት ስንት ይሆናሉ	1. አንድ 4. ሶስት 2. ሁለት 5. አራት 3. አምስትና ከዚያ በላይ	
107	¾መÚ ረሻ ልï ዕድሜ ስንት ይሆናል	1. ____. አመት ____. ¨ ር	
108	ተጨማሪ ልጆች ለመውለድ ይፈልጋሉ	1-አ 3- ባለቤቴ ያውቃል 2-አልፈልግም 4- ግዚአብሔር ያውቃል• 99. መልስ አልተሰጠም	

109	ተሀ ማሪ ልፗ መ¨ ሰድ ከፈሰጉ መቼ መውሰድ Ãðልዕሉ	1-አሁኑኑ• 4-እስከ ሶስት ዓመት 2-� ቆከ አንድ ዓመት 5-ከሶስት አመት በኋላ 3-� ቆከ ሁለት ዓመት 99.-መልስ አልተሰጠም	
110	አሁን ጡት ያጠባሉ	1. አ 2. አላጠባም	
111	የትምህርት ደረጃ ምን ያህል ነው	1. ማንበብና መጻፍ የማይችሉ 2. ማንበብና መፃፍ ብቻ 3. አንደኛ Åረጽ ¾ሀ ረሱ /1-8/ 4. ሁለተኛ Åረጽ ¾ሀ ረሱ /9-12ኛ/ 5. 12+1 •ና ከዚያ በላÃ	
112	ሐይማኖት ምንድነው	1-ኦርቶዶክስ 3- ካቶሊክ 2-ኘሮቴስታንት 4-ክርስታያን ሌላ /ÃÑMê/ 3-� ቆልምና	
113	ብሔረሰብ ምንድነው	1. አኙª ¡ 6. Ñራ Ñ 2. ኑዌር 7. ከንባታ• 3. መዥንግር 8. ትግሬ 4. ኦሮሞ 9. አማራ 5. ሌላ /ÃÑMê/_______________.	
114	ሥራ ምንድነው	1-የመንግስት ሠራተኛ 5-የቤት እመቤት 2-የግል መሥሪያ ቤት ተቀጣር 6-ተማሪ 3-ነጋዴ ሴተኛ 7-አዳሪ 4-ሥራ ðላÑ 8-ሌላ /ÃÑMê/	
115	¾ ር ÑL ምን ያህል ነው	1. _______________ብር	
116	ከቤት ከዚህ ጤና ድርጅት ለመድረስ ምን ያሕል Ñ²› Ãሀ ርስብተል	1. ከግማሽ ሰዓት በታች 2. ከግማሽ ሰዓት� ቆከ አንድ ሰዓት 3. ከአንድ ሰዓት •እስከ ሁለት ሰዓት 4. ከሁለት ሰዓት በላይ 88. አላውቀውም	

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117	ለቤተሰብ ምጣኔ አገልግሎት ከዛሬ በፊት መØተዎ Á¨ ቃሉ	1. አ 2. ¾ለም	
118	ዛሬ ወደዚህ ጤና ድርጅት የመጡበት ዋና ምክንያት ምን ነበር	1. ስለወሊድ መቆጣጠሪያ ዘዴ መረጃና የምክር አገልግሎት ለማግኘት 2. ለመËመሪÁ Ñ²› ¾ቃዘዘልኝ የወሊድ መቆጣጠሪያ ዘዴ ለማÓኘት 3. ለስድስት ወርና ከዚያ በላይ ያቋረጥኩትን የወሊድ	125

		መቆ× ÖሪÂ ²È •እንደገና ለመጀመር 4. •እየተጠቀምኩት ያለሁትን የወሊድ መቆጣጠሪያ መድሀኒት ለማግኘት /የቤተሰብ ምጣኔ አገልግለት ክትትል ለማድረግ/ 5. ከዚህ በፊት •እየተጠቀምኩት የነበረ ግን ከስድስት ወር ወዲህ ያቋረጥኩትን የወሊድ መቆጣጠሪያ መድሀኒት አይነት •እንደገና ለመቀጠል 6. ከዚህ በፊት •እየተጠቀምኩት የነበረ ግን ከስድስት ወር ወዲህ ያቋረጥኩትን የወሊድ መቆጣጠሪያ መÉሀኒት ወደሌላ ዘዴ አስቀይሬ መጠቀም ለመጀመር 7. •እየተጠቀምኩት ስላለሁት የወሊድ መቆጣጠሪያ ዘዴ ችግር ለማማከር 8. ሌላ /ከቤተሰብ ምጣኔ አገልግሎት ውጭ የሆነ/-----------	119 135
119	ለባለፉት ስድስት ወራት ውስጥ የትኛውን የወሊድ መቆጣጠሪያ ዘዴን ይጠቀሙ ነበር?	1-ኪኒን 6- በመርፌ መልክ የሚሰጠውን 2- በማህፀን የሚቀመጥ 7- ፀረ ወንድ ዘር ፍሬ /ፍሳሽ ቅባት/ 3-ኮንዶም 8- በክንድ ላይ የሚቀበር 4-ማህፀን መቋጠር 9-ኮንዶምና ሌላ ²È 5-የማሕፀን ቆብ 10-ሌላ ÃÑካê 99. መልስ አልተ ሰጠም	
120	አገልግሎት የሚሰጥዎት ባለሙያ ስለምትጠቀሙት የወሊድ መቆጣጠሪያ ²È Òር ተÁÃዞ ÁÒÖመት የጤና ችግር ካለ ÖÃቆት ያውቃል	1. አ 2. ³ለም	
121	ከምትጠቀሙት የወሊድ መቆጣጠሪያ ዘዴ የተነሳ ችግር አጋጥሞት ያውቃል	1. አ 2. ³ለም___________________________.	125
122	የወሊድ መቆጣጠሪያ አገልግሎት ³ኖሚሰØት ባለሙያ የርሶን ችግር ለመረዳት ይሞክራል	1. አ 2. ³ለም	
123	የወሊድ መቆጣጠሪያ አገልግሎት ³ኖሚሰØት ባለሙያ የጋጠሞትን ችግር ለመቅረፍ ምን ማድረግ ⍰ ኟዳለብት መፍትሔ ሰጥቶል	1. አ 2. ³ለም	
124	ችግርትን ለመፍታት በተሰÒት ምክር /ህክምና/ ረክተዋል	1. አ 2. ³ለም	
125	ዛሬ ያመጡት የወሊድ መቆጣጠሪያ ዘዴ ለማÓኘት ነው	1. አ 2. ³ለም_____________________________.	127

126	ወደዚህ ሲመጡ የትኛውን የወሊድ መቆጣጠሪያ ዘዴ ለመድሰድ ፈልገው ነው	1-ኪኒን በመርፌ 6. መልክ የሚሰጠውን 2-በማህፀን የሚቀመጥ 7. ፀረ ወንድ ዘር ፍሬ /ፍሳሽ ቅባት 3-ኮንዶም 8. የማሕፀን ቆብ 4-ማህፀን መቋጠር 9. ኮንዶምና ሌላ ዘዴ 5-በክንድ ላይ የሚቀበር 10. ሌላ ይገለጽ 88. አላውቅም	
127	የወሊድ መቆጣጠሪያ አገልግሎት ¾ሚሰØት ባለሙያ ስለየትኛ¨ ‹ ¾ ሊÉ መቆጣጠሪያ ዘዴ ነገርት /አማከርት/	1-ኪኒን 6-በመርô መልክ የሚሰጠውን 2-በማህፀን የሚቀመጥ 7- ፀረ ወንድ ዘር ፍሬ /ፍሳሽ ቅባት/ 3-ኮንዶም 8-በክንድ ላይ የሚቀበር 4-ማህፀን መቋጠር 9-ኮንዶምና ሌላ ዘዴ 5-የማሕፀን ቆብ 10-ሌላ ÃÑlê 88. አላውቅም	
128	ዛሬ የወሊድ መቆጣጠሪያ ዘዴ ተሰጥቶ•ል	1. አ --------- 2. ¾lም	130
129	³ሬ ¾ ሊÉ መቆ× Öሪ ²È ታዞሎታል	1. አ •ታዞልኛል 2. አ ከሌላ ጤና ተቋም •ንደማገኝ ተነግሮኛል 3. የለም/ግን የወሊድ መቆጣጠሪያ ዘዴው በተራ ቁጥር 127 ተÑlï ል/________________. 4. ¾lም /¾ ሊÉ መቆ× Öሪ ²È¨ ‹ በተራ ቁØር 127 አልተገለፀም/________________.	131 135
130	ዛሬ የትኛ¨ ‹ ¾ ሊÉ መቆ× Öሪ ²È ተሰጥቶታል /[illegible] ጁዲወስዱ [illegible] ፉሎ-ታል/ተነግሮታል/	1-ኪኒን በመርፌ 6-መልክ የሚሰጠውን 2-በማህፀን የሚቀመጥ 7-ፀረ ወንድ ዘር ፍሬ /ፍሳሽ ቅባት/ 3-ኮንዶም 8-በክንድ ላይ የሚቀበር 4-ማህፀን መቋጠር 9-ኮንዶምና ሌላ ዘዴ 5-የማሕፀን ቆብ 10-ሌላ ÃÑlê 88. አላውቅም	
131	(በመረጃ ሰብሳቢ ¾ሚሞላ) ³ሬ ¾ ሊÉ መቆጣጠሪያ ተጠቃሚ የራሱን ምርጫ አግኝቷል /በጥያቄ ተ.ቁ 126 •ና 130 ¾lሰØትን የወሊድ መቆጣጠሪያ ዘዴ [illegible] Ã/ ¾lሰØት የወሊድ መቆጣጠሪያ ዘዴ በØÁቂ ቁØር 126 •ና 130 ከተገለፀው ጋር አንድ አይነት ነው	1. አ /ተጠቀሚው የራሱን ምርጫ አግኝቷል 2. ተጠቃሚው የራሱ ምርጫ አልነበረውም 2. የለም ተጠቃሚው የራሱን ምርጫ አላገኘም-----	133 132
132	በጥያቂ 126 የተጠቀሰውን የወሊድ መቆጣጠሪያ ዘዴ ዛሬ ለምን ማግኘት ያለቻሉ ይመስልታል	1-ምርጫዬን አልተቀበሉትም 2-ምርጫዬ ትክክል አልነበረም /ከመድሀኒት ተቃርኖ ጋር ተÁÃዞ/ 3-አገልግሎት ሰጪው ሌላ ዘዴ አንድጠቀም ስለመከረኝ 4-የአገልግሎት ሰጪውን ምክር ከሰማሁት በኋላ ሀሳቤን	

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133	ለመውሰድ የወሰኑትን ዛሬ የወሊድ መቆጣጠሪያ ዘዴ ያዘዘልት ባለሙያ		
133.1.	ስለወሊድ መቆጣጠሪያ አጠቃቀም አገልግሎት በሚገበ ገልፆልታል	1. አ 2. የለም 88. አላውቅም /አላስታ¨ ‹ስም/	
133.2.	ሊከሰቱ የሚችሉ የጎንዮሽ ጉዳቶች Ñልï ልታል	1. አ 2. የለም 88. አላውቅም /አላስታ¨ ‹ስም/	
133.3.	ከወሊድ መቆሐጠሪያው ጋር በተያያዘ ችግር ቢያጋጥምት ምን ማድረግ ? ሕዳለብት ነግርታል	1. አ 2. የለም 88. አላውቅም /አላስታ¨ ‹ስም/	
133.4.	¾ሰØት የወሊድ መቆጣጠነያ ከኤች አይ ቪ/ኤድስ •ና ከአባላዘር በሽታች ? ሕደማይከላከል ተገልጾልታል (ኮንደም ከሆነ አይጠየቅ)	1. አ 2. የለም 88. አላውቅም /አላስታ¨ ‹ስም/ 99. አያስኬድም /ኮንደም ከሆነ/	
134	በጥያቁ ቁጥር 130 የተሰጠውን ወይም የታዘዘውን የወሊድ መቆጣጠሪ ዘዴ በማክበብ የተያያዘውን መጠይቅ ÃÖÃቁ		
134.1	ኪኒን	ኪኒን በምን ያህል ጊዜ ይወስዳሉ	1-በቀን አንድ ? እስርለሁ 2-ሌላ 99. አላውቅም
134.2.	በማህፀን የሚቀመጥ	በማህፀን የሚቀመጠውን በቦታው መሆኑን ? ሕዴት ያረጋግጣሉ	1. በብልት ውስጥ ክሮች መኖራቸውን በ¾Ñ²¸¨ ‹ በመርሰስ 2. ሌላ 88. አላውቅም
134.3.	በመርô መል¡ ¾ሚሰØ	በመርô መል¡ ¾ሚሰÖ¨ ‹ ¾ ሊÉ መቆጣጠሪያ ዘዴ ለምን ያህል ጊዜ ÁÑÖላል	1. ለሦስት ወር 2. ሌላ 88. አላውቅም
134.4.	በክንድ ላይ የሚቀበር	በክንድ ላይ የሚቀበር የወሊድ	1. ለአምስት አመት

		መቆጣጠሪያ ዘዴ ለምን ያህል ጊዜ ÁÑክÓላል	2. ሌላ 88.አላውቅም
134.5.	ኮንዶም /የሴትም የወንድም/	አንድ ኮንዶም ለምን ያህል ጊዜ ÃÖቀማሉ	1. ለአን ድግዜ 2. ሌላ 88.አላውቅም
134.6.	የማህፀን ቆብ	የማህፀን ቆብ ከግንኙነት በኀላ ለምን Áህል Ñ²› በቦታዉ መቀመØ አለበት	1- ቢያንስ ለስድስት ሰዓት /ከ24 በላይ ያልቆየ/ 2-ሌላ 88-አላውቅም
135	ለክትትል መቼ መምጣት ? ጼደልብት ተነግርታል	1. አ 2. ¾ለም 88. አላውቅም /አላስታ¨ሱም/	
136	ከባለሞያው ጋር ስለ ወሊድ መቆጣጠሪያ ዘዴ በምትወያዩበት ወቅት ጥያቄ ለመጠየቅ የተመቸ ሁኔታ• ነበር	1. አ 2. ¾ለም 88. አላውቅም /አላስታ¨ሱም/	
137	በዛሬው የክትትል ጊዜ የወሊድ መቆጣጠሪያን በተመለከተ የተሰጠት መረጃ ? ጼዴት ነበር	1-በጣም አነስተኛ 2- በቂ ነበር 3-ከበቂ በላይ 88. አላውቅም	
138	በዛሬው ክትትል የማህፀን ምርመራ ተÅርያልት ነበር	1-አ 2. ¾ለም_________.	140
139	ምርመራ¨ ¾ተÅረÑልት ለብቻ •ና አመቺ በሆነ ቦታ• ነበር	1. አ 2. ¾ለም 88. አላውቅም /አላስታ¨ሱም/	
140	ከአገልግሎት ሰጪው ጋር ለክትትል ተገናኝታችሁ በምትመካከሩበት ወቅት የምትመካከሩትን ሌላ ሰው ይሰማል ብለ¨ Áስባሉ	1. አ 2. ¾ለም 88. አላውቅም	
141	የወሊድ መቆጣጠሪያን በተመለከተ ከአገልግሎት ሰጪው ጋር የሚለዋወጡት መረጃ በሚስÖር ? ጼደሚይዝ ያምናሉ	1. አ 2. ¾ለም 88. አላውቅም	
142	ወደዚህ ክሊኒክ ለክትትል በመጡበት ወቅት በባለሙያ የሚሰጠውን አገልግሎት እንዴት አዩት	1. በ×ም Øሩ 2. Øሩ 3. በ×ም Øሩ አልነበረም/ደካማ ነበር/	
143	ወደዚህ ክሊኒክ ለክትትል በሚመጡበት ወቅት በሌሎች ባለሙያች ¾ሚሰጠውን አልግሎት ? ጼዴት አዩት	1. በ×ም Øሩ 2. Øሩ 3. በ×ም Øሩ አልነበረም/ደካማ ነበር/ 4. ሌላ ባለሙያ አልነበረም	

144	ክሊኒኩ አገልግሎት የሚሰጥበት ሰዓት ለርሶ አመቺ ነው	1-አ 2. ¾ለም 88. የመከፈቻ ሰዓቱን አላውቅም 99. መልስ ¾ለም	
145	ወደ ክሊኒክ ከመጡበት ሰዓት ጀምሮ አገልግሎት እስከ አገኙበት Ñ²› É ረስ ምን ያህል ጊዜ ቆይተዋል	1. ከ15 ደቂቃ በታች 2. ከ16-30 Åቂቃ 3. ከ31-45 Åቂቃ 4. ከ46-60 Åቂቃ 5. ከ61-90 Åቂቃ 6. ከ91-120 Åቂቃ 7. ከ120 ደቂቃ በላይ 99. አላውቅም	
146	አገልግሎቱን ለማግኘት የጠበቁት ጊዜ እንዴት ያዩታል	1. አልቆየሁም 2. ምክንያታዊና አጭር ነበር 3. በ× ም ረÏ ም ነበር 88. አላውቅም	
147	አገልግሎቱን ከሚሰጡት በለሙያ ጋር በሚነጋገሩበት ጊዜ ስለ ኤችአይቪ/ኤድስ •ና አባላዘር በሽታች ተወያይተው ነበር	1. አ 2. ¾ለም 88. አላውቅም /አላስታ¨ ‹ስም/	
148	አገልግሎት የሚሰጥት ባለሙያ ከተሰጥዋት የወሊÉ መቆ× Ö ሪÁ ²È በተጨማሪ ኮንደምን እንዲጠቀሙ Áበረታታ ነበር	1. አ 2. ¾ለም 88. አላውቅም /አላስታ¨ ‹ስም/ 99. አያስኬድም/ኮንደም ከሆነ/	
149	ከአገልግሎት ሰጪው ጋር የሚያደርጉት ¾ØÁ¡¡ C ና የውይይት ጊዜ እንዴት Á¿ታል	1. ትክክልና በቅ ነው 2. በጣም አጭር/ በቅ አይደለም/ 3. በ× ም ረÏ ምና አሰለች ነው 88. አላወቅም/አላስተ¨ ‹ስም	
150	ስለወሊድ መቆጣጠሪያ አጠቃቀም አገልግሎት የምሰጥት የባለሙያ ምክር በቀላሉ Ã ረÅሉ	1. በቀላሉ •ረዳለሁ 2. በቀላሉ አልረዳም 3. አልረዳም 88. አላውቅም /አላስተ¨ ‹ስም/	
151	ለወሊድ መከላከያ ዘዴውና ለአገልግሎቱ ይከፍላሉ	1. አ 2. ¾ለም	
152	የከፈሉ ከሆነ ለአንድ ጉብኝት ምን ያህል ይከፈላሉ	1. ለ¨ ሊÉ መቆ× Ö ሪÁ ብር 2. ለአገልግሎት ብር	
153	አገልግሎት ሰጭው ለሚቀጥለው ቀጠሮ መቸ •እንደሚመለሱ	1. አ	

	ነግሮታል?	2. የለም /አልተነገረኝም 99. መልስአልተሰጠበትም	
154	በሚቀØለ¨ ቀÖሮ Äመለሣሉ	1. አ 2. ¾ለም 99. መልስ አልተሰጠም 88. አላውቅም	

¡õል 2: ለተÖቃሚች በሚሰጠው አገልግሎት ላይ የሚቀረብ ቃለመጠይቅ /ለአዲስ •ና ለነባር ተጠቃሚ"ች

¡õል 3:- ከዚህ በታች በሠንጠረዥ የተጠቀሱትን ነጥቦች ተጠቃሚች በአገልግሎት ላይ ያላቸውን የተለያዩ ፍ ፎካታች ያሳያሉ:: ተጠቃሚች በጣም የማይስማሙበት ከሆነ በጣም አልስማማም ከሚለው ላይ ምልክት (√)ያድርጉ:: የማይስማሙበት ከሆነ አልስማማም ከሚለው ላይ ምልክት(√)ÁÉርÑ:: በመሰማማትና በላመስማማት መካካል ከሆና ታህቅቦ ከሚለዉ ለይ ምልክት (√)ያድርጉ:: የሚስማሙበት ከሆነ ፍ ቆማማለ¨ ¾ሚለ¨ ላÃ(√) ምልክት ያድርጉ:: በጣም የሚስማሙበት ከሆነ በጣም ፍ ቆማማለሁ ¾ሚለ¨ ላÃ (√)ምልክት ÁÉርÑ::

ተ.ቁ	የአገልግሎት ዓይነቶች	1 በ× ም አልስማማም	2 አልስማ ማም	3 ታህቅቦ	4 እስማማለሁ	5 በ× ም እስማማለሁ
155	ክሊኒኩ አገልግሎት የሚሰጥበት ሰዓት ምቹ ነው::					
156	የአገልግሎት ሰጪው ሰላምታና አቀባበል ጥሩና የንደኝነት ስሜት አለው					
157	አገልጋዩ የሚሠራቸውን ሥራች በንጽህናና በጥራት ያከናውናል					
158	አገልግሎት ሰጪው ለሚሰራቸው ሥራች ጥሩ ፍ ዉቀትና ችሎታ አለው					

159	በአገልግሎት ሰጪው የሚሰጠው ም¡ ር Óልê ና በቂ ነው					
160	ከዚህ ጤና ድርጅት በቂና የተለያዩ የመከለከያ ዘዴች ይገኛሉ					
161	ስለሚወስዱት የወሊድ መቆጣጠሪያ ²È ¾ተሰÖት መረጃ በቂ ነው					
162	ወደ ክሊኒኩ ከደረሱበት አገልግሎት � ቅካÑኙበት ያለው የመቆያ ጊዜ በቂና አግባብ ነው					
163	የምክር አገልግሎት የሚሰጥበት ለብቻና አመቺ ቦታ• አለው					
164	¾መቆÁ ቦታው ሽንት ቤት � ጁዲሁም ውሃ ያለውና በቂ ነው፡፡					