ASSESSMENT OF QUALITY OF SAFE ABORTION SERVICE PROVISION: CLIENT-PROVIDER INTERACTION IN SAFE ABORTION SERVICE IN PUBLIC AND PRIVATE HEALTH FACILITIES OF ADAMA TOWN, OROMIYA, ETHIOPIA

BY

BARUDIN SHERIF, [BSc]

A THESIS SUMMITED TO THE COLLEGE OF PUBLIC HEALTH AND MEDICAL SCIENECES, DEPARTMENT OF HEALTH SERVICE MANAGEMENT, JIMMA UNIVERSITY IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF PUBLIC HEALTH IN HEALTH SERVICE MANAGEMENT

JANUARY 2014

JIMMA, ETHIOPIA

JIMMA UNIVERSITY

COLLEGE OF PUBLIC HEALTH & MEDICAL SCIENCE

POST GRADUATE SCHOOL

DEPARTMENT OF HEALTH SERVICE MANGEMENT

ASSESSMENT QUALITY OF SAFE ABORTION SERVICE PROVISION: CLIENT-PROVIDER INTERACTION IN SAFE ABORTION SERVICE IN PUBLIC AND PRIVATE HEALTH FACILITIES OF ADAMA TOWN, OROMIYA, ETHIOPIA .

BY

BARUDIN SHERIF [BSc]

.

<u>ADVISOR</u>

ELIAS ALI YESUF (MD,MPH)

JANUARY 2014

JIMMA, ETHIOPIA

Abstract

Background

Globally each year nearly 42 million women faced with unintended pregnancies have abortions, of which 20 million are unsafe, mostly in countries where abortion is illegal. The problem is clearly visible in Africa where around 4 million unsafe abortions occur each year. In Ethiopia, the health service are limited and of poor in quality. Only a few studies on client-provider interaction conducted in safe abortion care in Ethiopia and in the study area, as a result there is a gap of information concerning client-provider interaction.

Objective

To assess quality of client-provider interaction in comprehensive abortion care in health facilities of Adama Special administrative Town.

Methods

A facility based cross-sectional study was conducted. Data collection tools were direct service observation, client exit interviews and provider interview were used for the assessment. Data analysis was computed by SPSS. A total of 6 heath facilities were selected from Adama town. A single population proportion with assumption of 50% good client-provider interaction was carried out to include 399 safe abortion service users in the study area.

Results

Overall, data from service delivery observation showed that 332 (83.2%) of observed service procedure had good client-provider interaction. NGO health institution and high education level has an association with good client-provider interaction.

Conclusion

Client-provider interaction was generally good. However it is suggested that creating a mechanism to enhance providers existing skill towards client interaction and attitude towards dealing with cases of safe abortion.

Keywords: client-provider interaction, quality, comprehensive abortion care, health facility/clinics.

Acknowledgment

I would like to thank my advisors Dr. Elias Ali Yesuf for the very detail, exhaustive and constructive comments. Jimma University, College of public health and medical sciences, Department of Management for giving this chance to prepare the thesis.

I am thank to the respondent of the study, Adama Special Administrative Town health office, staff, staff of the respected health facilities, data collectors and supervisor of the study for facilitating the data collection processes.

Table of content

Contents

Abstract ii
Background ii
Objective ii
Methods ii
Results ii
Conclusion ii
Acknowledgment iii
Table of content iv
List of table vi
List of annex vii
Acronyms and Abbreviations viii
Chapter 1: Introduction 1
1.1 Background Information 1
1.2. Statement of the problem 2
Chapter 2: Literature review 5
Conceptual framework 9
2.1 Significance of the study 10
Chapter 3: Objectives 11
3.1 General Objective 11
3.2. Specific Objectives 11
Chapter 4: Methods and Materials 12
4.1. Study area and period 12
4.2. Study design 13
4.3. Population 13
4.3.1. Source Population 13
4.3.2. Study Population 13
4.3.3. Study unit 13
4.4. Inclusion and exclusion criteria 13

4.4.1. Inclusion criteria 13
4.4.2. Exclusion criteria 13
4.5. Sample size determination and sampling technique 13
4.5.1. Sample size determination 13
4.5.2. Sampling techniques 14
4.6. The study variable 15
4.6.1. Dependent variable 15
4.6.2. Independent variable 15
4.7. Data collection instrument and methods 16
4.8. Data Quality Assurance` 17
4.9. Data processing and analysis: 17
4.10. Operational definition 18
4.11. Ethical Clearance 19
4.12. Dissemination of the result 20
Chapter 5. Result 21
5.1. Socio- demographic characteristics of CAC client respondents 21
5.2. Provider characteristics 23
5.4. Client-provider interaction (CPI) observation 25
5.4.1. Public health facilities 25
5.4.2. NGO clinics 26
5.4.3. Private for profit clinics 27
5.5. Socio-demographic characteristics of the client and client-provider interaction for exit interview. ... 32
5.6. Health institutions and pattern of client-provider interaction 34
Chapter 6 Discussion 36
6.1 Strength and weakness of the study 38
Chapter 7. Conclusion and recommendation 39
7.1 Conclusion 39
7.2. Recommendation 39
11. References 40
12. Annex 43

List of table

Table 1 Socio-demographic distribution of CAC clients, public, NGO and private health facilities of Adama Town, October 2013, Adama Ethiopia 21
Table 2 Occupational and household economical status distribution of CAC client in public, NGO and private for profit health facility Adama Town, October 2013, Adama Ethiopia 22
Table 3 Marital status, Religion, Ethnicity, professional qualification, sex and age distribution of service provider, in public, NGO and private for profit health facilities of Adama Town, October 2013, Adama Ethiopia 23
Table 4 Observational result of client-provider interaction in safe abortion service, public, NGO private and private for profit health facilities Adama Special Administrative Town, October 2013, Adama Ethiopia 29
Table 5 Client socio-demographic characteristics and good client-provider interaction in public, private and NGO health facilities in Adama Town, October 2013, Adama Ethiopoia 32
Table 6 Types of health facilities and good client-provider interaction in public, NGO and private health facilities in Adama Town, October 2013, Adama Ethiopia. 34

List of annex

Annex 1 Checklist used for Observation 43
Annex 2 Questionnaire Designed for provider Interview (English) 45
Annex 3 Questionnaire Designed for Exit Interview (English) 48
Annex 4 Questionnaire Designed for Exit Interview (Oromifa) 52

Acronyms and Abbreviations

AIDS	Acquired Immune-Deficiency Syndrome
CAC	Comprehensive Abortion Care
CPI	Client-Provider Interaction
DHS	Demographic and Health Survey
EDHS	Ethiopia Demographic and Health Survey
EFMoH	Ethiopian Federal Ministry of Health
EVA	Electric Vacuum Aspiration
FP	Family Planning
FPANCO	Family Planning Association of Nepal Central Office
GCAC	Global Comprehensive Abortion Care
HIV	Human Immune Deficiency Virus
IEC	Information, Education and Communication
IPC	Inter Personal Communication
IPPF	International Planned Parenthood Federation
IUCD	Intra-Uterine Contraceptive Device
LMP	Last Menstruation Period
MoH	Ministry of Health
MVA	Manual Vacuum Aspiration
NGO	Non-Governmental Organization
PAC	Post Abortion Care
QoC	Quality of Care
RH	Reproductive Health
SDP	Service Delivery Point
STI	Sexually Transmitted Infection

Chapter 1: Introduction

1.1 Background Information

The unwanted and unintended pregnancies are directly related to abortion practices. Socio-cultural values, belief system, religious norms and expectations, poverty and low level of awareness among community people are hindering the access to safe abortion services in most of the rural and some of the urban areas. Social stigma and discrimination exists against those who undergo induced abortion. All these issues finally compel people to undergo unsafe abortion and conceal the case. Implications of unsafe abortion on health are major factors leading to high maternal mortality and morbidity. Unsafe abortion results into adverse impact not only on health but also on socio-economic status of people [1].

According to WHO report, globally, each year nearly 42 million women faced with unintended pregnancies have abortions, of which 20 million are unsafe, mostly in countries where abortion is illegal. The problem is clearly visible in Africa where around 4 million unsafe abortions occur each year, and where 1/3 of the total death from unsafe abortion takes place. WHO has estimated that at least 33% of all women in the world who seek hospital care for abortion complication are less than 20 years of age [2]. public health problem caused by unsafe abortion is largely preventable, by improving the quality and availability of post abortion care, by making abortion legal and increasing access to safe abortion services, and by expanding access to contraceptive information and service because most abortion is preceded by unintended pregnancy [3]

Ethiopia, being one of the least developed countries where induced abortion is illegal unless done to save the life of the mother, fetal deformity, and pregnancy follows Rape or incest, pregnancy occurs in minors, mother is physically and mentally unable to care for the would-be born child [4].

Induced abortion is increasing problem especially in urban areas, where socio economic pressure to space and limit birth in general is greatest but least recognized human right abuse. If often goes unnoticed and undocumented party due of growing nature concern over violence against women [5].

1.2. Statement of the problem

Every year between 40-60 million unsafe abortions, take place globally. Nearly 90% takes place in developing world. As estimated by WHO worldwide about 50 million unsafe abortions are performed outside the health care system. This is one of the common causes of maternal mortality and morbidity [2].

The problem is clearly visible in Africa where around 4 million unsafe abortions takes place in each year and where 1/3 of the total death is from unsafe abortion. Ethiopia being one of the developing countries and is quite clear that unsafe abortion is common [2]. According to the Ethiopian Federal Ministry of Health [EFMOH], abortion accounts for nearly 60% of gynecological and almost 30 % of all obstetric and gynecological admissions [4]. Maternal death due to unsafe abortion account 32% in Ethiopia [6]. However, this public health problem caused by unsafe abortion is largely preventable, by improving the quality and availability of post abortion care, by making abortion legal and increasing access to safe abortion services, and by expanding access to contraceptive information and service because most abortion is preceded by unintended pregnancy[3].

In response in part to increasing evidence on abortion-related maternal mortality, the parliament passed the penal code on abortion in March 2005. This new penal code added indication for rape, incent, fetal abnormality, and a women's physical or mental abnormalities. According to the law, no consent from a spouse, partner or parent is required to obtain a legal abortion and no requirements exist for legal reporting or documenting rape or incest as a prerequisite for obtaining a legal abortion. In addition, in 2006 the Ministry of Health issued Technical guidelines for implementing safe abortion care [4].

In Ethiopia, health services are limited and of poor quality and the country has extremely poor health status relative to other low-income countries [7]. Despite different progress have been increased by the government still there is low healthcare utilization in different settings. Since the country's abortion law reform in 2005, efforts have been made to improve and expand abortion care services around the country. As noted by a national representative studies conducted in 2008 indicates that only 27% (103,000) women had access to safe and legal safe abortion procedures in health facilities. In addition, the national annual abortion rate was 23 per 1,000 women aged 15-44 [8].

Providing high-quality abortion care requires attention to several aspects of services in addition to the clinical or technical competence of health care providers. Also important are the use of appropriate abortion technology and the availability of equipment, supplies and medications necessary to use the technology safely. Critical components of the care that need to be provided to women include the way that staff and clients interact, the information and counseling that are available to women, and the contraceptive and other reproductive health services available on site or by referral along with community linkage. Most importantly, women's needs will not be met if care is not accessible to women because of obstacles such as distance, inconvenient service schedules, and lack of affordability or cultural norms, to name a few. The quality of care therefore calls for addressing different aspects of abortion care to provide high-quality services [1].

Besides, quality of care is a core aspect of safe abortion services and plays important role for ensuring clients' Sexual and reproductive health rights and providers' rights. As quality of health care has multiple dimensions; one should look from the side of all involved including the provider. As provider's perspective is very important because client satisfaction largely depends on their interaction with providers more likely to comply with treatment and to continue to use health service which is very relevant in the case of safe abortion care [1].

Good client-provider interaction involves a two-way exchange of information between client and providers. In order to have Good interaction between provider and client, provider gives information and service such as treating client respectfully, making them feel comfortable, asking not judgmental questions, and respecting clients privacy and confidentiality, focusing on clients' concern and better meet their need. However, if a provider gives biased or insufficient information, is not aware of the client's specific needs, fails to ask about a client's previous experiences with reproductive health services, or does not acknowledge their circumstances, the interaction is unlikely to achieve its potential [9].

The study conducted in Ghana showed that providers in private health facilities interact with client betters than providers in public health facilities. This study revealed that provider ensured privacy for 36.8% in public and for 98.7% in private; and assured confidentiality for 17.6% in public and for 96.1% in private during safe abortion care provision. In addition, information provision on contraceptive option is the weakest part of care in public sectors, and the strongest part in the private sectors [10].

The study conducted in private health facilities in Addis Ababa revealed that providers used IEC material during counseling/education session for 14.5% of client [11]. In addition the study conducted in government health facilities in Guraghe zone indicated that providers offered information pertaining to complications or danger signs for 34.5% of cases were told to revisit the facility if the danger sign happens [12].

As noted by study conducted in selected health facilities in Addis Ababa on heath provider perception towards safe abortion service showed that a majority health provider (96.4%) recognized that unsafe abortion a serious health problem. Health providers who had experience on safe abortion practice were more likely to have favorable attitude towards safe abortion than those without practice. In addition, providers who had knowledge of the law governing abortion were more likely to have favorable attitude than those who lack this knowledge. Further this study noted that training of health providers on safe abortion and reproductive rights are important to reduce maternal mortality [13].

Studies on abortion in Ethiopia have given less attention to client and provider interaction in safe abortion services; as a result there is a gap of information concerning client-provider interaction (CPI) from provider and client perspective in safe abortion care in Ethiopia as well as in the study areas.

Besides, it is currently recognized more than ever that the quality of health care is built on the premise that optimal health care can best be achieved in the context of long term relationship between providers and patients [14, 15]. However, only a few studies on client-provider interaction conducted in safe abortion care in Ethiopia. Therefore the objective of this study was to assess client-provider interaction of comprehensive abortion care in public and private health facilities of Adama Special administrative town, Ethiopia.

Chapter 2: Literature review

Since 1980, there have been improvements in safety of abortion in developing countries through improved service provision and training of providers, development of relatively easier and safer procedures, like manual vacuum aspiration, and through legalization of abortion [16, 17]. However, According to WHO report, globally, each year nearly 42 million women faced with unintended pregnancies have abortions, of which 20 million are unsafe, mostly in countries where abortion is illegal. The problem is clearly visible in Africa where around 4 million unsafe abortions occur each year, and where 1/3 of the total death from unsafe abortion takes place. In addition, WHO has estimated that at least 33% of all women in the world who seek hospital care for abortion complication are less than 20 years of age [2]. public health problem caused by unsafe abortion is largely preventable, by improving the quality and availability of post abortion care, by making abortion legal and increasing access to safe abortion services, and by expanding access to contraceptive information and service because most abortion is preceded by unintended pregnancy [3]

In Ethiopia unsafe abortion is major contributor to maternal mortality, which accounts about 32% of all maternal death in the country [3,5]. According to HSDP IV reported maternal mortality reduced to 590 (from 673 in 2005) per 100,000 live birth in 2010, but still the highest among the world [18]. The severity of abortion complications and case fatality rate rose from 1.1% in 2003 to 3.6 % in 2008. Limited access to contraceptives for all age groups of women has been identified as a major factor of unwanted pregnancy and then, induced and even spontaneous abortion in some studies. The case fatality rate among women seeking post abortion care in public hospitals were the most serious complications seen (628 per 100,000) in 2007 [3, 19, 20].

Safe abortion is believed to reduce unsafe abortion and its consequences. Quality of care is a core aspect of safe abortion services and plays important role for ensuring clients' Sexual and reproductive health (SRH) rights and providers' rights. Client- provider interaction one of key component of high –quality of service which affects all aspect of reproductive health care [1].

The client-provider interaction is the fundamental steps for service delivery. Because it leads directly better health outcomes and client satisfaction largely depends on their interaction with providers. Also, Better interaction leads to enables patients to disclose critical information about their health problems and providers to make more accurate diagnoses. In addition, good

interaction enhances health care education and counseling, resulting in more appropriate treatment regimes and better patient compliance [9].This indicates it has an effect in reducing maternal mortality and morbidity.

"Client- provider interactions" reference to the interpersonal exchange between a client who receives health information and services and health providers who offer these services. Good client-provider interaction involves a two-way exchange of information between client and providers. In order to have Good interaction between provider and client, provider gives information and service such as treating client respectfully, making them feel ease, asking not judgmental questions, and respecting clients privacy and confidentiality, focusing on clients' concern and meet better their need. However, if a provider gives biased or insufficient information, is not aware of the client's specific needs, fails to ask about a client's previous experiences with reproductive health services, or does not acknowledge their circumstances, the interaction is unlikely to achieve its potential [21].

Communication is an exchange of ideas, information or thoughts in writing or orally during social interactions between two or more groups of individuals. It is the verbal or nonverbal transfer and exchange of information between entities [22]. Effective communication between patient and health care providers is an essential element for improving patient satisfaction, treatment adherence and health outcomes. Also, client who understand their problem of illness and its treatment and feel that health care providers is concerned about their health show greater satisfaction with the care received and are more likely to comply with treatment regimens [23]. As noted by a previous study effective communication associated with positive health outcomes [24].

The emphasis gained on the importance of Client-provider interaction (CPI) in family planning and other reproductive health service gained an important attention since 1994 in fourth ICPD held in Cairo and more on fifth Cairo assessment [25]. Today, "Good client-provider interaction characterize includes such as courtesy, clarity, more listening and less "telling" on the part of the provider; encouragement of the client to ask questions and seek clarification; attention to sexuality and gender issues; discussion of contraceptive methods' side effects; inquiry about the client's risk of sexually transmitted infections (STIs), including HIV/AIDS [26]."

In the relationship between patient and health care providers, the frequency of meeting with the same providers and patient and the nature of the interaction affect the quality of care [27]. In social roles of the health care providers and patients, the role of physician is seen as complementary to the role of the patient. The physician is expected to apply his knowledge and skill for the benefit of the patient, just as the patient expected to cooperate with each other. This argument indicates that general expectation guides the behavior of both physician and patient and how this role facilitates interaction of consultation, because both parties know how to behave each other's [28].

The most common complaints about physicians by patients and the public issue to communication are such as, not to listen, not to provide sufficient information and show a lack of concern or respect for the patient. Due to this many patients leave the consultation without asking about their issues that troubling or do not get satisfactory response to their concern. However, even having less power than the physician in the consultation, patient can influence the interaction and the physician's communication skills, characteristics and behavior. The patient's passive communication styles and unwilling to give information to physician, influence not only their relation but also decision-making in treatment option and procedure [29].

The study conducted in Ghana revealed that providers in private health facilities interact with client betters than providers in public health facilities. This revealed that provider ensured privacy for 36.8% in public and for 98.7% in private; and assured confidentiality for 17.6% in public and for 96.1% in private during safe abortion care provision. In addition, information provision on contraceptive option is the weakest part of care in public sectors, and the strongest part in the private sectors [10].

The study conducted in private health facilities in Addis Ababa in the observation of 76 clients during consultation of safe abortion care provision revealed that providers used IEC material during counseling/education session for 14.5% of client [11].

In addition the study conducted in government health facilities in Guraghe zone indicated that providers offered information pertaining to complications or danger signs for 34.5% of cases were told to revisit the facility if the danger sign happens [12].

As noted by a study conducted in Tigray, 31% of women receiving abortion services with contraceptive methods. Out of these 52% of abortion cases received contraceptive method from health centers and 28% received from hospital, which indicates below the recommended level. The reason for low utilization of post-abortion contraceptives could be such as lack of awareness and skill of providers in delivering post-abortion contraceptives; poor setup of service delivery to properly link abortion care with post-abortion contraceptive services; incomplete of cases of referral for and receiving post-abortion contraceptive in other units [30].

As noted by study conducted in selected health facilities in Addis Ababa on heath provider perception towards safe abortion service showed that a majority health provider (96.4%) recognized that unsafe abortion a serious health problem. Health providers who had experience on safe abortion practice were more likely to have favorable attitude towards safe abortion than those without practice. In addition, providers who had knowledge of the law governing abortion were more likely to have favorable attitude than those who lack this knowledge. Further this study noted that training of health providers on safe abortion and reproductive rights are important to reduce maternal mortality [13].

According to WHO Standards in delivering comprehensive abortion care, the major elements are: counseling, Manual Vacuum Aspiration (MVA), post CAC contraceptive methods, and complication identification and management, including referral if needed. Comprehensive abortion care services includes examination by the trained doctor or health worker, counseling on abortion and family planning options and services, abortion service using MVA, effective pain management and other reproductive health services if needed [31].

According to Technical and Procedural Guidelines for Safe Abortion Services in Ethiopia, the Woman-centered abortion care is a comprehensive approach to providing abortion services that takes into consideration the various factors that influence a woman's individual mental and physical health needs, her personal circumstances, and her ability to access services. This care includes a range of medical and related health services that support women in exercising their sexual and reproductive rights. The three key elements of women-centered abortion services are: choice, access and quality. Choice: which comprises of the right to determine if and when to become pregnant, to continue or terminate a pregnancy, to select between options, and to have complete and accurate information. Access: which includes having access to termination of

pregnancy services that are provided by trained and competent providers with up-to-date clinical technologies and that are easy-to-reach, affordable, and non-discriminatory. Quality: which refers to respectful, confidential services that are tailored to each woman's needs using accepted standards and appropriate referral procedures [3].

In this study attempt was made to assess client-provider interaction in safe abortion care service provision in public, NGO and private for profit health facilities in Adama Special Administrative town.

Conceptual framework

This conceptual framework consists of three domains of independent variables such as service provider related variables, patient related variable and health facilities related variables.

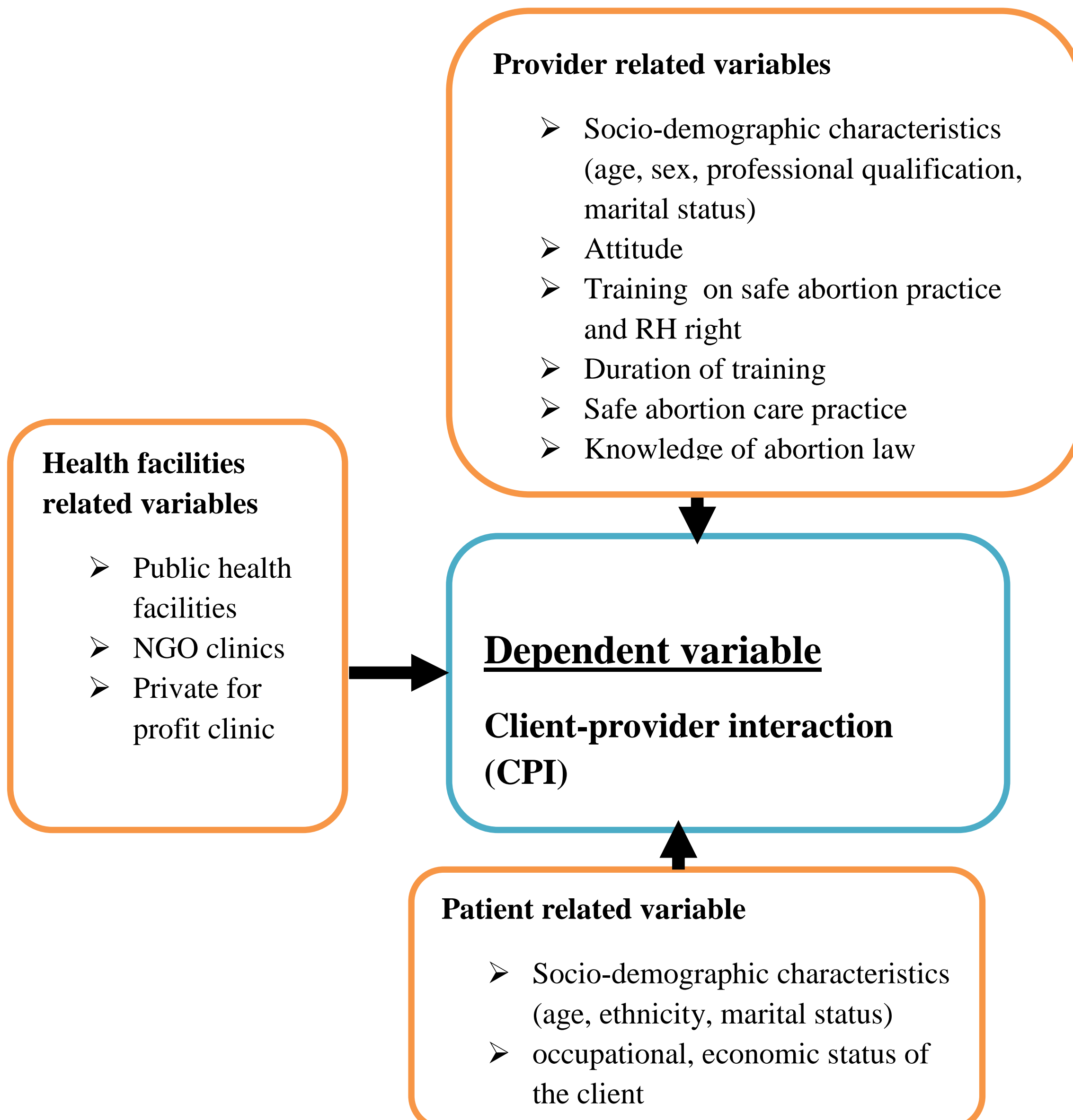

Figure -1 Framework for client- provider interaction for safe abortion care

Source: Adopted from IPPF conceptual framework for abortion related care

2.1 Significance of the study

Safe abortion is believed to reduce unsafe abortion and its consequences. Quality of care is a core aspect of safe abortion services and plays important role for ensuring clients' Sexual and reproductive health (SRH) rights and providers' rights/needs. Client-provider interaction (CPI) one of key component of high–quality of service which affects all aspect of reproductive health care (1).

Beside, knowing client-provider interactions in safe abortion services support the role of public, NGO and private for profit health facilities in improving clients' sexual and reproductive health (SRH) rights and providers' need.

As there is a gap of information concerning client-provider interaction (CPI) in CAC service provision in Ethiopia as well as in the study area. This study was conducted to assess the client-provider interaction (CPI) in safe abortion care service in public, NGO and private for profit health facilities.

The finding of this study could be to provide information that will help the health system managers and health facilities service providers to improve quality of safe abortion care through improved client-provider interaction in the study area and in Ethiopia.

Chapter 3: Objectives

3.1 General Objective

To assess client-provider interaction of comprehensive abortion care in public and private health facilities in Adama Special administrative Town, Oromiya National Regional State of Ethiopia.

3.2. Specific Objectives

1. To measure the level of client-provider interaction in safe abortion care provision.

3. To identify the association of socio-demographic characteristic client and client-provider interaction.

3. To determine the association of health facilities type and client-provider interaction.

4. To determine the provider related characteristics in safe abortion service provision.

Chapter 4: Methods and Materials

4.1. Study area and period

Adama special Administrative Town is one of the 27 Town Administrative zones of Oromia region state, which is located in central part of Ethiopia and surrounded by East Shewa zone it is located at 8.550N 39oE. at an elevation of 1712 meters, 99Km southeast of the Ethiopian capital, Addis Ababa.

The administrative organization, Adama Special administrative includes 14 urban kebeles and 4 surrounding rural kebeles. Total population of Adama Special Administrative Town based on the 2007census conducted by CSA, this town has a total population of 311,483. Of these the total female population and reproductive age group women in the town constitute about 51% and 22.2% of the total population composition, respectively.

The four largest ethnic groups reported in Adama were the Oromo (39.02%), the Amhara (34.53%), the Gurage (11.98%) and the silte (5.02%); all other ethnic groups made up 9.45% of the population [32].

In the town there are one referral and teaching public hospital and four public health centers, one non-governmental health center, three private for profit hospitals and 60 private clinics. Among these health facilities, all public health facilities (1 hospital and 4 health centers), two NGO clinics (one International and one local clinic); from private for profit health facilities two hospital and one clinic are providing safe abortion services.

Adama hospital is referral and teaching hospital has 11 CAC service provider (2 gynecologist, 8 trained nurse and 1 midwife), Adama health centers has 3 service providers (2 nurse and 1 midwife), and Biftu health centers has 2 health officers service providers. In non- profit, private clinics, International Marie Stops clinics there are 5 service providers (1 gynecologist, 3 trained nurse and 1 midwife) and FGAE clinic has 8 trained service providers (1 physician, 2 nurse and 5 midwife) and private for profit clinic has 3 service providers (one gynecologist, 1 trained nurses and 1 untrained nurses).

According to Adama health office report of 2012/13, a total of 5854 induced abortion procedure were performed in all health facilities, out of these 1517 cases from public health facilities (945 from hospital and 572 from 4 health centers), 3799 cases from NGO clinics (1146 from FGAE

and 2653 from Mary stop clinics) and 538 cases from private for profit health facilities (63 from Sister Aklisiya hospital, 18 Medhanalem General hospital and 457 from Kiduse clinic).

The study was conducted from September 15 to October 30 2013.

4.2. Study design

A facility based cross-sectional studies was used.

4.3. Population

4.3.1. Source Population

Women who had got CAC services and service providers directly involved in CAC services in all health facilities that provide CAC service were source populations.

4.3.2. Study Population

Women who had got CAC services and health care providers directly involved in CAC services in selected health facilities that provide CAC service during the study period.

4.3.3. Study unit

women who had got CAC services and health care providers directly involved in CAC services in selected health facilities that provide CAC service (six health facilities) who were fulfilled inclusion criteria and available during the study period.

4.4. Inclusion and exclusion criteria

4.4.1. Inclusion criteria

All safe abortion service users and service providers who directly involved and available during the study period in selected health facilities.

4.4.2. Exclusion criteria

- Client who the severely ill were excluded from the study.

4.5. Sample size determination and sampling technique

4.5.1. Sample size determination

The sample size was determined using single population proportion with the following assumptions (95% confidence interval, $Z\alpha/2 = 1.96$ was taken). A 5% level of precision ($d = 0.05$)

and proportion of good client- provider interaction with CAC service was considered (P = 50%). Therefore the total sample size for this study was 422 women seeking CAC service including 10% none response rate. All health care providers who were directly involved in CAC service at the studied health facilities during the study period were included.

All CAC service users consecutively from the selected health facilities were included in the study until the required number of cases reached and all interviewed women were also observed.

4.5.2. Sampling techniques

All the health facilities which provide the CAC in Adama Town were listed and divided in five strata

1. Hospital
2. Health centers
3. International NGO clinics
4. Local NGO clinic
5. Private for profit

Two public health centers were selected from four health centers using simple random sampling methods. And one public hospital, two NGO clinics (one International and one local clinic) and one private for profit clinic were included in the study. Accordingly, one public hospital, two public health centers, one international clinics, one local NGO clinics and one private clinics providing CAC service were studied until the required sample size were obtained for observations and exit interviews. The sample size (n=422) was allocated proportionally according to the number of CAC client flow (case load) one year data of 2012/13. All CAC service users consecutively from the selected health facilities who met the inclusion criteria were included in the study until the required number of cases reached.

The duration of data collection was designed until the required sample size was obtained from September 15 to October 30 and 399 cases treated for CAC at the selected facilities during the survey period were studied.

Sampling technique and sample unit distribution

All health facilities in Adama Town which provide CAC service were identified and listed

1 years CAC user = 5392

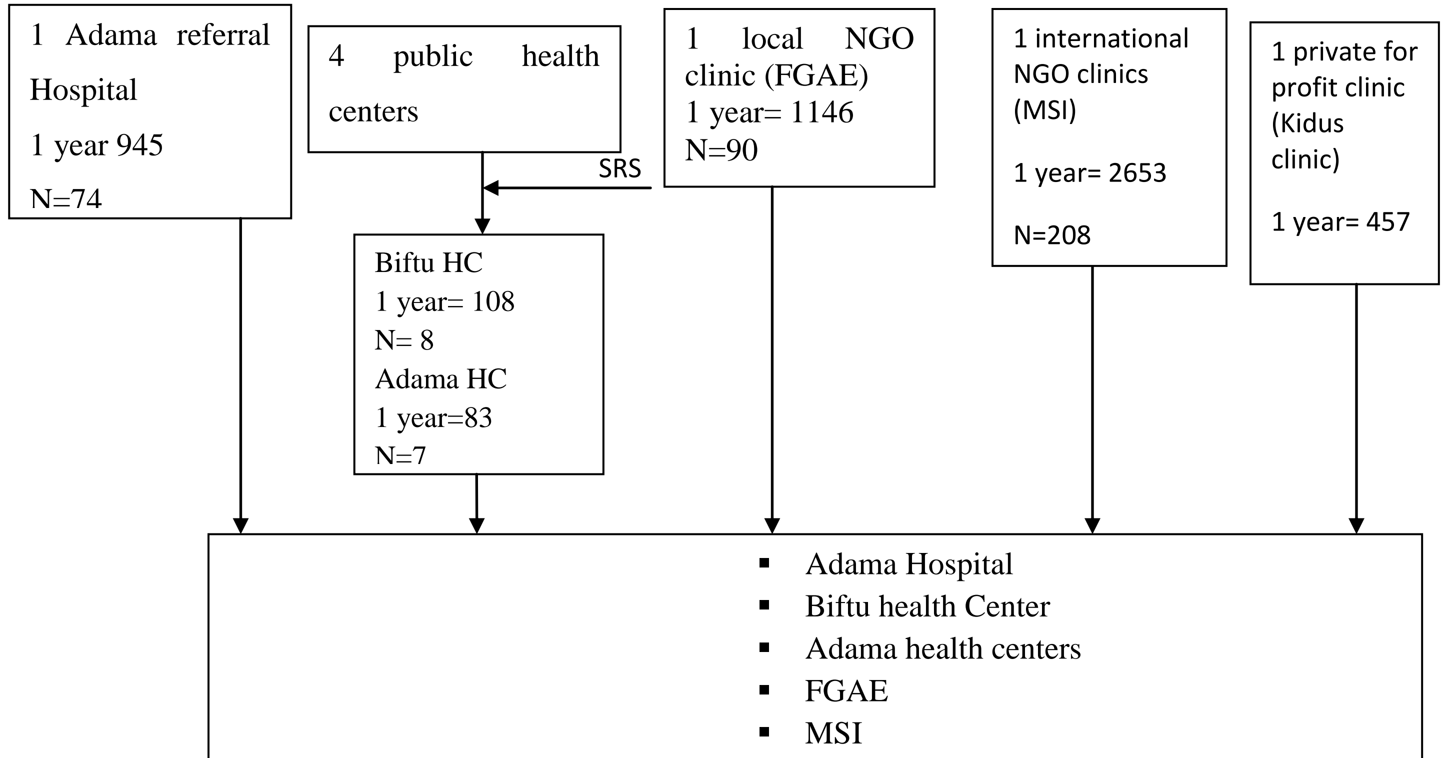

Figure 1 schematic sampling technique and unit distribution

4.6. The study variable

4.6.1. Dependent variable

Client–provider interactions in comprehensive abortion care.

4.6.2. Independent variable

1. Provider characteristics (such as age, sex, marital status, religion, Ethnicity, professional qualification, attitude, training on safe abortion care and reproductive health right and duration of training).

2. Client characteristics (such as age, marital status, ethnicity, religion, occupational and household economical status of client).

3. Types of health facility (public health facilities, NGO clinics and private for profit clinics).

4.7. Data collection instrument and methods

Study instruments include adaptation of quality of care CAC service standards and protocols of IPPF [33]. Mainly an observational checklist was used. The checklist addressed issues of such as providers greeting client respectfully, assuring privacy, ensuring confidentiality, and information and counseling on family planning. In addition, a tool was developed for exit interviews to addressed issue of client socio-demographic characteristics like age, sex, religion, ethnicity, educational status, occupational status and household economical status. Further short structural interview developed for service providers to addressed issue of such as age, sex, provider's qualification, training background and attitude towards abortion client and services.

Twelve field staff (six nurses and six 10/12 completed data collectors) were recruited. The six nurses were selected from two health centers that not included in the study. Client exit interviewing was done by 10/12 completed data collectors. Female were preferred to conduct the interviews because our study participants were females and it was highly likely that they provide unbiased information to female interviewers. The data collectors were trained for two days by the principal investigator on the objectives of the study and how to conduct the interview, and fill in the questionnaire. Data from service providers was collected using interviewing by structured questionnaire in English. Nurses who have received training on comprehensive CAC conducted the service delivery observation using a check list. They received a one day orientation on methodology of observation.

The observation of client consultation was conducted using ID number provided for the client in waiting areas after informed objective of the study. The observer was in white coats and remained inconspicuous so as not to interfere with routine service provision. Before providers were interviewed, their informed consent was sought. In case of observations of client-providers interactions, permission was sought from both the provider and client before the consultation and the start of the data collection. A two-step consent process was followed to obtain consent from the client. First, a provider asked the client about her willingness to participate in the research. Clients who agreed were then approached by the interviewer and asked if they were willing to be interviewed. In the case of client exit interviews, only those clients who were to be interviewed after they had recovered sufficiently from the procedure were included.

Recognizing the social stigma surrounding abortions and the sensitivity of the topic, the research team took steps to minimize discomfort to clients and providers by being unobtrusive to protect

the privacy of the client, conducting interviews in privacy and of keeping in strict confidence any information gathered during the consultation and interview process. In order to ensure anonymity and confidentiality of responses, names and address of clients and providers were also not collected.

4.8. Data Quality Assurance`

Observation checklist was used for the observation of client-provider interaction during CAC service provision and inventory checklist for assessment of clinical set up facilities were adopted from quality of care CAC service standards and protocols of IPPF. A structured questionnaire for client exit and short structure questionnaires for provider were adapted from similar study in Ethiopia and modified to the study context by reviewing other previous similar studies. Its English version was translated into Oromifa and again back to English so as to ensure its consistency. The questionnaire was pretested on 20 clients in Gada health and corrections were made on omitted, an answerable or unclear questions accordingly. Five percent of the data was reentered and compared with the already entered data by other person. Finally 10% collected data was checked by the fist a devisors.

4.9. Data processing and analysis:

Data were obtained from client-provider interaction observation; client exit interview; provider interviews; and health facilities inventory were coded and entered to SPSS version 16 for analysis. Frequency distributions were obtained to check for data entry errors (e.g. unrecognized or missing codes). Descriptive statistics was computed and binary logistic regression was also conducted to examine the effect of selected variables on client- provider interaction. Crude odds ratio with 95% confidence interval from bivariate analysis was used to identify candidate variable for multivariate analysis at cut point of 0.25 was used. Adjusted odds ratio with 95% confidence interval from multivariate analysis was used to determine association between dependent and independent variables at a significance level of .05 was used.

To measure information provided to client during consultation of client-provider interaction using result from the observation checklist. CAC service provider observation checklist was used in assessment of CPI, twenty seven observation items of which provided during consultation of CAC client. Each item was assigned a value of “1” (yes) if performed correctly for each client was summed to create a “client-provider interaction score”. Thus, the total possible score of the provider could achieve was 27 if provider performed every steps. Client-provider interaction was

considered good if they performed greater than 14 of observation items correctly and poor if performed less than or equal to 14 observation items. In addition, GCPI should consider aspect of ensuring privacy, assuring confidentiality, informing on need of contraceptive, explaining the available CAC service and client to ask the question and responded to client correctly (performed at least 4 out of 5).

The result of CPI presented on three thematic areas whether client treated in a friendly and respectful manner by service provider; the provider skill, knowledge, and empathy; and providers ensure proper referral and follow up of the client after procedure by the types of health facilities.

The household economical status was assessed using the available data on household assets and other housing characteristics. Using factor score analysis, household wealth quintile was calculated and ranked into five groups to assess the household economical status of client characteristics (poorer, poor, rich, richer, richest).

4.10. Operational definition

"Abortion care" to refer to services for induced abortion of a viable pregnancy

Client-provider interaction: in this study CPI measure the extent to which relevance information was given to clients in relation to their CAC service procedure. To measure CPI Service provider observation checklist was used; twenty seven observation items of which provided during consultation of CAC client. Assigned a value of "1" for each item if performed correctly for each client was summed to create a "client-provider interaction score". Client-provider interaction was considered good if they performed greater than 14 of observation items correctly and poor if performed less than or equal to 14 observation items. Considering aspect care that have high importance during CPI should be included in GCPI these are ensuring privacy; assuring confidentiality; provide information on need of contraceptive, encourage client to ask question and responded to their question correctly and provide information to client how to care at home (perform at least 4 out of 5).

Client occupational status- In the study Britain socio-economic classification of occupation was used. In the study, Higher manger, Admin & professionals includes cabinets, Hospital mangers & engineer, Intermediate manger, Admin & professionals include Health professionals, accountant and merchants, Supervisors Junior Admin & professionals include supervisors and

hourly employ skilled manual workers includes driver, farmer using tractor to cultivate, mechanics and carpenter & lowest grade worker includes farmer using ox to cultivate & students .

Household economical status – household economical status was measured using the available data on household assets and other housing characteristics. Using factor score, household wealth quintile was calculated and ranked into five groups to assess the household economical status of client characteristics (poorer, poor, rich, richer, richest). The client wealth quintile classification using those household assets commonly found in poorer group and those rarely household assets found the richest.

Providers: refers to health professionals involved in history taking, physical examination, treatment and counseling of safe abortion cases.

Provider Attitude: A CAC service providers' views (values and beliefs) about a safe abortion care or client that often lead to positive or negative behaviour.

Safe abortion - Safe abortion is the termination of a pregnancy by trained health care providers using correct, sanitary technique and proper equipment—is a simple, life saving health service.

Unsafe abortion --"a procedure for terminating an unintended pregnancy carried out either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both"

Unwanted pregnancies are defined as those that occur at an inopportune time, as a result of unfavorable circumstances, or among women who do not want to have children

4.11. Ethical Clearance

Ethical clearance was obtained from Jimma University institutional research ethics review committee. An official letter of co-operation was also written to the Oromiya health bureau and Adama health office. Before providers were interviewed, their informed consent was sought. In case of observations of client-providers interactions, permission was sought from both the provider and client before the consultation and the start of the data collection. Confidentiality was maintained by avoiding names and other personal identification information whereas

privacy was maintained by conducting the exit interview in a separate room that offered visual and auditory privacy.

4.12. Dissemination of the result

The result of the study will be reported to Jimma University, Regional Health Beuro and Adama special Administrative town health office and other organization or institution or individuals who have direct or indirect input to the project. All attempts will be made to present the results of the study on local and/or international Journals.

Chapter 5. Result

5.1. Socio- demographic characteristics of CAC client respondents

Client exit interview: a total of 399 safe abortion service users were observed and interviewed yielded a response rate of 95%. Eighty nine (22.3%) were from public health facilities (one hospital and 2 health centers), 282 (70.7%) from two NGO clinics and 28 (7%) from one private for profit clinic.

Concerning educational status, grade 10+1 and above accounts 123 (30.8%) of the CAC clients' population and 106 (26.6%) of them completed secondary school.

Three hundred four (76.3%) of the CAC service consumers at all health facilities were urban dwellers and 258 (64.7%) Orthodox Christian in religion. Amhara and Oromo ethnic dominated more [Amhara 147 (36.8%); Oromo 176 (44.1%)]. The minimum age is 15 and the maximum is 40 years. The overall mean age of exit interview CAC clients was 23.6±4.6. More than two-third of the CAC clients (70.9%) are in the age group of 20 and 29 years. Especially girls within the age of 20 and 24 years took major (42.6%) of CAC population (Table.1).

Table 1 Socio-demographic distribution of CAC clients, public, NGO and private health facilities of Adama Town, October 2013, Adama Ethiopia

Attribute	Scale of measurement	Frequency(n=399)	Percentage
Residence	Urban	304	76.2
	Rural	95	23.8
Age	15-19	77	19.3
	20-24	170	42.6
	25-29	113	28.3
	30-34	25	6.3
	35-39	13	3.3
	40-44	1	.3
Educational status	Illiterate	30	7.5
	Write and Read only	46	11.5
	Primary school [1-8]	94	23.6
	Secondary school completed	106	26.6
	10+1 and above	123	30.8
Marital status	Single	179	44.9
	Married and living together	176	44.1
	Married, but not living together	9	2.2
	Divorced	23	5.8
	Windowed	7	1.8

	No steady partner	5	1.2
Ethnicity	Oromo	176	44.1
	Amhara	147	36.8
	Gurage	29	7.3
	Siliti	27	6.8
	Others	20	5.0
Religion	Muslim	82	20.6
	Orthodox	258	64.7
	Protestant	58	14.5
	Other	1	.3

The larger proportion of CAC client's population 110 (27.6%) were state dependent, causal, and lowest grade worker. Ninety one (22.8%) were intermediate managerial, administrative or professional. Regarding to household economical status, the proportions of CAC client's population were distributed almost equally among the wealth quintiles (Table.2).

Table 2 Occupational and household economical status distribution of CAC client in public, NGO and private for profit health facility Adama Town, October 2013, Adama Ethiopia

Categories	**public health facilities (n=89)**	**NGO clinics (n=282)**	**Private for profit clinics (n=28)**	**Total (n=399)**
Occupational status				
Higher managerial, administrative, or professional	16(18%)	41(14.5%)	3(10.7%)	60(15%)
Intermediate managerial, administrative, or professional	12(13.5%)	70(24.8%)	9(32.1%)	91(22.8%)
Supervisory, clerical, junior administrative and professional	2(2.2%)	11(3.9%)	1(3.6%)	14(3.5%)
Skilled manual	21(23.6%)	47(16.7%)	5(17.9%)	73(18.3%)
Semi skilled and unskilled manual	8(9%)	39(13.8%)	4(14.3%)	51(12.8%)
State dependents, causal and lowest grade workers	30(33.7%)	74(26.2%)	6(21.4%)	110(27.6%)

Wealth quintile				
Poorer	10(11.2%)	65(23%)	4(14.3%)	79(19.8%)
Second	14(15.7%)	56(19.9%)	12(42.9%)	82(20.6%)
Third	24(27%)	48(17%)	5(17.9%)	77(19.3%)
Fourth	22(24.7%)	56(19.9%)	3(10.7%)	81(20.3%)
Richest	19(21.3%)	57(20.2%)	4(14.3%)	80(20.1%)

5.2. Provider characteristics

Provider interview: of a total of 18 service providers, 6 (4 male and 2 female) from public health facilities, 9 (4 male and 5 female) from NGO clinics and 3 (1 male and 2 female) from private for profit clinics directly involved in the provision of CAC were interviewed. Ten (55.6%) of the service provider were between 30-34 and 24-29 years. From total of service provider 9 male and 9 female. Sixteen (77.8%) of the service provider are married. In addition twelve (66.7%) providers was follower of Orthodox Christian, followed by Muslim 4 (22.2%) and protestant account about 2 (11.1%). The majority 14 (77.8%) of service provider were nurse, 3 (17.7%) were health officer and one (5.6%) gynecologist. Five (39%) and four (22.2%) of provider were work in current facility for 1-5years and 6-10 years respectively (table.3).

Table 3 Marital status, Religion, Ethnicity, professional qualification, sex and age distribution of service provider, in public, NGO and private for profit health facilities of Adama Town, October 2013, Adama Ethiopia

Categories		**Public health facilities(n=6)**	**NGO private clinics (n=9)**	**Private for profit clinics (n=3)**	**Total (n=18)**
Sex of provider	Male	4(66.7%)	4(44.4%)	1(33.3%)	9(50%)
	Female	2(33.3%)	5(55.6%)	2(66.7%)	9(50%)
					18(100%)
Age	24-29	2(33.3%)	1(11.1%)	2(66.7%)	5(27.8%)
	30-34	3(50%)	2(22.2%)	0	5(27.8%)
	35-39	0	2(22.2%)	0	2(11.1%)
	40-44	0	2(22.2%)	0	2(11.1%)
	45-59	0	0	1(33.3%)	1(5.6%)
	>50	1(16.7%)	2(22.2%)	0	3(16.7%)
					18(100%)

Professional qualification	Nurse	4(66.7%)	8(88.9%)	2(66.7%)	14(77.8%)
	Health officer	2(33.3%)	1(11.1%)	0	3(16.7%)
	Gynecologist	0	0	1(33.3%)	1(5.6%)
					18(100%)
Marital status	Single	1(16.7%)	2(22.2%)	1(33.3%)	4(22.2%)
	Married and living together	5(83.3%)	5(55.6%)	2(66.7%)	12(66.7%)
	Married, but not living together	0	2(22.2%)	0	2(11.1)
					18(100%)
Religion	Muslim	1(16.7%)	2(22.2%)	1(33.3%)	4(22.2%)
	Orthodox	3(50%)	7(77.8%)	2(66.7%)	12(66.7%)
	Protestant	2(33.4%)	0	0	2(11.1%)
					18(100%)
Service time	less 10 years	2(33.3%)	1(11.1%)	2(66.7%)	5(27.8%)
	10-20 years	3(50%)	4(44.4%)	1(33.3%)	8(44.4%)
	more than 20 years	1(16.7%)	4(44.4%)	0	5(27.8%)
					18(100%)
working experience in current facility	less than 1year	1(16.7%)	0	0	1(5.6%)
	1-2years	1(16.7%)	0	1(5.6%)	2(11.1%)
	3-5 years	1(16.7%)	4(44.4%)	0	5(27.8%)
	6-10 years	1(16.7%)	3(33.3%)	1(50%)	5(27.8%)
	more than 10 years	2(26%)	2(22.2%)	1(50%)	5(27.8%)
					18(100%)

Training background: Regarding training background 17 (94.4%) providers have taken CAC training (MVA & MA) including the law safe abortion care and only one (5.6%) service provider in private clinic has not taken CAC training but involving in service provision. Regarding the time of training 14 (82.4%) service providers trained before one years (4 public, 8 NGO and 2 private for profit) while 3 (17.6%) of less than one years. Only 6 (2 from public, 3 from NGO and 1 from private for profit) taken CAC refreshment training while 12 (66.7%) do not have. In addition ten (55.6%) of provider have taken training on FP counseling and method provision and reproductive related issue, 3 (50%) from public, 6 (66.7%) from NGO clinics and 1(33.3%) from private for profit clinics.

Provider's attitude: all of service providers responded that women who want safe abortion service should not be denied the services. Similarly, a majority 17 (94.6%) of them believe that

women who want safe abortion services deserve equal attention to other women seeking medical services. Twelve (66.7%) of health providers were comfortable in dealing with cases of safe abortion. Interestingly, 6 (33.3%) of service providers admitted that they are not comfortable dealing with cases of safe abortion, of these 4 (22.2%) from NGO clinics and 2 (11.1%) from public health facilities. Fifteen (83.3%) of the respondents believed that all women including married, unmarried and adolescents deserve equal attention while three health providers (one from each of public, NGO, private and private for profit health facilities) believe do not.

5.4. Client-provider interaction (CPI) observation

A total of 399 comprehensive abortion care users were observed (89 from public, 282 from NGO and 28 from private for profit). Providers were observed on 27 observations items to measure client-provider interaction on three thematic areas whether client treated in a friendly and respectful manner by service provider; the provider skill, knowledge, and empathy; and providers ensure proper referral and follow up of the client after procedure. The result presented on along the three thematic areas by the types of health facilities.

5.4.1. Public health facilities

A total of 89 comprehensive abortion care procedure observations were made in public health facilities. Out which 74 client-providers interaction observation was from Hospital and 15 form two health centers.

Regarding client treated in a friendlily and respectfully manner by service providers: for 8 (9%) of the cases, the providers were greeting respectfully to the client during initial contact. For three fourth [67(75.3%)] of cases providers listening patiently to client's need/concern without interrupting clients and for 77 (86.5%) used language that client understand easily. Although for 78 (87.6%) of cases the providers allow to see him alone/ensured privacy/, for 56 (62.9%) of cases not assured confidentiality (ranges 52.6% in hospital and 60% in health centers). For sixty (67.4%) of the cases, the providers were use language that supportive to client decision (not judgmental) (Table-4).

The service providers' skill, knowledge, and empathy: for about two third [61 (68.5%)] of cases the provider explained CAC service available (medical and surgical) in the facility. With regard to providers explaining to client about safe abortion procedure: 22 (24.7%) client informed how long the procedure would take; 69 (77.5%) client informed about pain medication; 27(30.3%)

client informed about benefit of the procedure; 45(50.6%) client informed possible side-effect of the procedure; 44 (49.4%) client informed recovery time and when to resume normal activities (including sexual activity); and 63 (70.8%) informed the possible complication and where to go for treatment. The majorities [82(92.1%)] of the cases were informed on contraceptive methods and 59 (66.3%) of client also provided or prescribed/linked to family planning. More than two third [62 (69.7%)] of clients providers were inform about the need for follow up and 54 (60.7%) of client encouraged asking question and they respond to their question correctly. For nearly two third [65 (73%)] of cases, provider allowed to make their own choice of service available. But only for 4 (4.5%) of the cases, the providers in public health facilities used IEC materials (models, diagrams) during client counseling/education session.

Regarding to service provider ensuring proper referral and follow up of client after procedure: forty six (51.7%) of cases informed about referral and follow up protocol. Only 23 (25.8%) of client, the provider direct the client where to go after procedure and 22 (24.7%) of cases follow in recovery room after the procedure. For less than fifty percent [40(44.9%)] of cases, the providers informed how to do self care at home and for one third [29 (32.6%)] of client recap the information provided at the beginning of session (table-4).

5.4.2. NGO clinics

A total of 282 client-provider interaction observations in comprehensive abortion care were made in NGO clinics (International Mary stop clinics and FGAE clinics). Out of which 192 client-providers interaction was from International Mary stop clinics and 90 from FGA clinics.

Regarding client treated in a friendly and respectfully manner: for two hundred twenty one (78.4%) of the cases, the provider were greet respectfully during initial contact. For two hundred thirty nine (84.8%) of the cases the providers listening patiently to client's need/concern and in 261 (92.6%) of cases used language that client understand easily. Although in almost all of [278 (99%)] of the cases the providers allowed the client to see him alone/ensured privacy/, for 134 (47.5%) of the cases the providers not assured confidentiality of the client. In 266 (94.3%) of the cases providers used language that supportive to client decision (not judgmental).

Service providers skill, knowledge, and empathy: In most [279 (98.9%)] of the cases the providers, explained CAC service available (medical and surgical) in the facility. With regard to providers explanation about safe abortion procedure: 211 (74.8) client informed how long the

procedure would take; 155 (55%) of client informed about pain medication; 235 (83.3%) client informed about benefit of the procedure; 106 (37.6%) client informed possible side-effect of the procedure; 85 (30.1%) client informed recovery time and when to resume normal activities (including sexual activity); and 152 (53.9%) of client informed the possible complication and where to go for treatment. The majority of [272 (95.5%)] of the cases were informed on contraceptive methods and 254 (90.1%) of cases provided or prescribed/linked to family planning. Less than two third [173(60.1%)] of clients were informed about the need for follow up. Two hundred forty three (86.2%) of client, the providers encouraged asking question and they respond to their question correctly. For majority of [278 (98.6%)] of cases, provider allowed making their own choice of service available. But only for one hundred thirteen (40.1%) of the cases providers in NGO clinics used IEC materials (models, diagrams) during client counseling/education session.

Regarding to service providers ensuring proper referral and follow up of client after procedure: for one hundred twenty three (43.6%) of the cases, provider informed about referral and follow up protocol. But for majority of [277 (98.2%)] of cases the provider directs the client where to go after procedure and for 249 (88.3%) of cases follow up in recovery room after the procedure. More surprisingly, only 93 (33%) of cases, the provider informed how to do self care at home. For more than four fifth [246 (87.2%)] of cases, the providers recap the information provided at the beginning of session (Table-4).

5.4.3. Private for profit clinics

A total of 28 comprehensive abortion care cases observations were made in private for profit clinics. And total of 3 service providers, 1 gynecologist and 2 nurse clinics were included.

Regarding to client treated in friendly and respectfully manner: for most 27 (96%) of the cases, the provider did not greet to client in the initial contact. For all the cases the providers used language that the client easily understand while in only 11 (39%) of the cases listening patiently to client’s need/concern. Also in all of observed cases the providers allow to see him alone/ensured privacy/ while in 15 (54.6%) of cases were not assured confidentiality. In more than three fourth [22 (78.6%)] of the cases, the provider used language that supportive to client decision (not judgmental).

Concerning to service providers skill, knowledge, and empathy: for twenty two (78.6%) of the cases, the providers explained CAC service available (medical and surgical) in the facility. With regard to information provided to client about safe abortion procedure: for six (21.4%) of client informed how long the procedure would take; for 10 (35.7%) of client informed about pain medication; for 8 (28.6%) of client informed about benefit of the procedure; for 10 (35.7%) of client informed possible side-effect of the procedure; for 11 (39.3%) of client informed recovery time and when to resume normal activities (including sexual activity); and for 11 (39.3%) 0f client informed the possible complication and where to go for treatment . For fourteen (50%) of the cases were informed on contraceptive methods and 12 (42.9%) of cases provided or prescribed/linked to family planning. For twenty one (75%) of clients were informed about the need for follow up while 12 (42.9%) of client encouraged asking question and they respond to their question correctly. All of cases allowed making their own choice of service available. But only five (17.7%) of the cases providers in private for profit clinics used IEC materials (models, diagrams) during client counseling/education session.

Regarding to service providers ensuring proper referral and follow up of client after procedure: for eleven (39.3%) of cases, provider informed about referral and follow up protocol. For all cases the provider direct the client where to go after procedure and for 27 (98.4%) of cases follow in recovery room after the procedure. For only seven (25%) of cases, the provider informed how to do self care at home. For most [25 (89.3%)] of cases, the provider recap the information provided at the beginning of session. But only for teen (35.7%) of the cases, the providers record all relevant information in client record/registration (Table-4)

In general, with regarding to client treated in friendly and respectfully manner by the providers were good across all the health facilities. Observation of consultations indicated that providers from NGO sectors facilities interacted with clients better than those from public and private for profit sectors on many items of care giving (Table-4). In particular, issues of greeting client respectfully were not addressed in public and private for profit sectors as the same extent as NGO sectors.

Regarding provider’s skill, knowledge, and empathy, observation of consultation indicated was good across all health facilities. The result indicated that providers in public health sectors interact better than private for profit sectors. In particular, explaining about the pain medication

procedure, explaining about the possible complication and where to for the treatment, explaining about the need of contraceptive and encouraging client to ask question and responding to them correctly.

Regarding Observation of the providers in ensuring proper referral and follow up of client after procedure showed that providers from NGO sectors consultation better than those of public and private for profit sectors (Table-4). In particular, service providers directed the client were to go after the procedure and recording all relevant information on a client record registration were not addressed in public and private for profit sectors as same extent as NGO sectors.

In general, with regarding to client treated in friendly and respectfully manner by the providers were good across all the health facilities. Observation of consultations indicated that providers from NGO sectors facilities interacted with clients better than those from public and private for profit sectors on many items of care giving (Table-4). In particular, issues of greeting client respectfully were not addressed in public and private for profit sectors as the same extent as NGO sectors.

Regarding provider's skill, knowledge, and empathy, observation of consultation indicated was good across all health facilities. The result indicated that providers in public health sectors interact better than private for profit sectors. In particular, explaining about the pain medication procedure, explaining about the possible complication and where to for the treatment, explaining about the need of contraceptive and encouraging client to ask question and responding to them correctly.

Regarding Observation of the providers in ensuring proper referral and follow up of client after procedure showed that providers from NGO sectors consultation better than those of public and private for profit sectors (Table-4). In particular, service providers directed the client were to go after the procedure and recording all relevant information on a client record registration were not addressed in public and private for profit sectors as same extent as NGO sectors.

Table 4 Observational result of client-provider interaction in safe abortion service, public, NGO private and private for profit health facilities Adama Special Administrative Town, October 2013, Adama Ethiopia

Attribute			Public health facilities n=89	NGO private clinics n=282	Private for profit clinic n=28	Total n=399
I.	**Client treated in a friendly and respectful manner by service provider**					
1.	Service provider greeting client respectfully	Yes	8(9%)	221(78.4%)	1(3.6%)	230(57.6%)
2.	Service provider give client an opportunity to see him alone/ensure privacy	Yes	78(87.6%)	278(98.6%)	28(100%)	384(96.2%)
3.	listening patiently to client's needs/concerns	Yes	67(75.3%)	239(84.8%)	11(39.3%)	317(79.4%)
4.	provider uses language that the client understands easily	Yes	77(86.5%)	261(92.6%)	28(100%)	366(91.7%)
5.	provider uses language that supportive of the client's decision (not judgmental)	Yes	60(67.4%)	266(94.3%)	22(78.6%)	348(87.2%)
6.	Provider assuring confidentiality of the client	Yes	33(37.1%)	134(47.5%)	13(46.5%)	180(45.1%)
7.	provider provides information to the partner or the carer (if present) on how to support the client	Yes	62(69.7%)	243(86.2%)	17(60.7%)	322(80.7%)
II.	**service provider's skill, knowledge, and empathy**					
8.	service providers explaining the CAC services available (medical & surgical) in the facility	Yes	61(68.5%)	279(98.9%)	22(78.6%)	362(90.7%)
9.	service provider explaining abortion procedure to client	Yes	87(97.8%)	282(100%)	28(100%)	397(99.5%)
10.	Explain how long the procedure will take?	Yes	22(24.7%)	211(74.8%)	6(21.4%)	239(59.9%)
11.	Explain pain medication procedure?	Yes	69(77.5%)	155(55%)	10(35.7%)	234(58.6%)
12.	Explain benefits of the procedures?	Yes	27(30.3%)	235(83.3%)	8(28.6%)	270(67.7%)
13.	Explain possible side-effects of the procedure?	Yes	45(50.6%)	106(37.6%)	10(35.7%)	161(40.4%)
14.	Explain recovery time and when to resume normal	Yes	44(49.4%)	85(30.1%)	11(39.3%)	140(35.1%)

	activity (including sexual activities)?					
15.	Explain possible complication and where to go for treatments?	Yes	63(70.8%)	152(53.9%)	11(39.3%)	226(56.6%)
16.	Explain about the need of contraceptive use?	Yes	82(92.1%)	272(96.5%)	14(50%)	368(92.2%)
17.	Explain the need for follow up?	Yes	62(69.7%)	173(61.3%)	21(75%)	256(64.2%)
18.	Explain other tests if any are to be performed (blood, urine, etc)?	Yes	15(16.9%)	121(42.9%)	18(64.3%)	154(38.6%)
19.	service provider encouraging client to ask questions and they responded to clients' questions correctly	Yes	54(60.7%)	243(86.2%)	12(42.9%)	309(77.4%)
20.	providers allow client to make her own choice of the services available	Yes	65(73%)	278(98.6%)	28(100%)	371(93%)
21.	provider use IEC materials (models, diagrams) during client counseling/education session	Yes	4(4.5%)	113(40.1%)	5(17.9%)	122(30.6%)
III.	**Service providers ensure proper referral and follow up of the client after procedure**					
22.	providers inform clients of referral and follow up protocols after the procedure	Yes	46(51.7%)	123(43.6%)	11(39.3%)	180(45.1%)
23.	service provider direct the client where to go after procedure	Yes	23(25.8%)	277(98.2%)	28(100%)	328(82.2%)
24.	provider follows up the client after the procedure in the recovery room or rest site	Yes	22(24.7%)	249(88.3%)	27(96.4%)	298(74.7%)
25.	service providers provide information to client how to care herself at home	Yes	40(44.9%)	93(33%)	7(25%)	140(35.1%)
26.	Is the service provider recaps on information given at the beginning of the session?	Yes	29(32.6%)	246(87.2%)	25(89.3%)	300(75.2%)
27.	Service provider	Yes	59(66.3%)	254(90.1%)	12(42.9%)	325(81.5%)

	offered/prescribed a modern Family planning method to client			

Overall a large proportion 332 (83.2%) of observed cases were from public health facilities, NGO and private for profit clinics had good client- provider interaction (GCPI). Out of these public health facilities accounts a proportion of 48(53.9%), 270(95.7%) for NGO clinics and 14(50%) for private for profit clinics.

5.5. Socio-demographic characteristics of the client and client-provider interaction for exit interview.

In order to assess the association between socio-demographic characteristics and good client-provider interaction both bivariate and multivariable logistic analysis were conducted. In bivariate binary logistic regression occupational status and educational status appears to be statistically associated with client-provider interaction. Six variables: age of the client, residence, marital status, educational status, occupational status and household economical status were found eligible for multivariate analysis. Multivariate binary logistic regression analysis showed that only educational status appeared `statistically associated with good client-provider interaction. The result showed that primary school completed [1-8] had 0.444 (95%CI 0.213-0.923) less likely to have good client-provider interaction than10+1 and above educated.

In this study no significant differences were identified in client-provider interaction based on, age, residence, religion, ethnicity, marital status, household occupational status and household economical status (Table .5).

Table 5 Client socio-demographic characteristics and good client-provider interaction in public, private and NGO health facilities in Adama Town, October 2013, Adama Ethiopoia

Categories	**Numbers (%)**		**COR95%CI**	**p-value**	**AOR 95%CI**
	PCPI	GCPI			
Age					
15-19	13(16.9%)	64(83.1%)	.335(0.275,1.491)	0.843	
20-24	27(15.9%)	143(84.1%)	1		

25-29	13(11.5%)	100(88.5%)	.391[.083, 1.856]	0.302	
30-34	1(4%)	24(96%)	.568[.121,2.66]	0.147	
Residence					
Urban	35(11.5%)	269(88.5%)	1		
Rural	19(20%)	76(80%)	.628[0.353,1.119]	0.037	
Marital status					
Single[constant]	27(15.2%)	151(84.8%)	.714[.407, 1.251]	0.211	
Married	20(10.8%)	166(89.2%)	1		
Not married	7(20%)	28(80%)	.548[.225, 1.337]	0.132	
Religion					
Muslim	11(13.4%)	71(86.6%)	0.778[.345,1.756]	0.972	
Orthodox	35(13.6%)	223(86.4%	1		
Protestant	8(13.8%)	50(86.2%)	.715[.281,1.817]	0.964	
Ethnicity					
Oromo	26(14.8%)	150(85.2%)	1		
Amhara	16(10.9%)	131(89.1%)	1.333[.732, 2.430]	0.302	
Gurage	5(17.2%)	24(82.8%)	1.067[.378, 3.008]	0.731	
Siliti	5(18.5%)	22(81.5%)	0.635[.247, 1.629]	0.615	
Educational status					
Illiterate	6(20%)	24(80%)	0.456[.167, 1.248]	0.126	0.396[.141, 1.111]
Write and Read	6(13%)	40(87%)	0.774[.294, 2.039]	0.539	0.771[0.288, 2.061]
Primary school [1-8]	21(22.3%)	73(77.7%)	0.429[.210, .877]*	0.013	0.444[0.213, .923]*
Secondary school completed	9(8.5%)	97(91.5%)	0.843[.391, 1.816]	0.741	0.807[0.368, 1.770]
10+1 and above	12(9.8%)	111(90.2%)	1		1
Occupational status					
Higher managerial,	11(18.3%)	49(81.7%)	1		

administrative or professional				
Intermediate managerial, administrative or professional	10(11%)	81(89%)	2.194[.945, 5.097]	0.206
Skilled manual	13(17.8%)	60(82.2%)	1.289[.571, 2.911]	0.938
Semi skilled and unskilled manual	4(7.8%)	47(92.2%)	3.067[1.029,9.143] *	0.117
State dependent, casual, and lowest grad workers	16(14.5%)	94(85.5%)	1.50[.702, 3.204]	0.519
wealth quintiles				
Poorest	3(3.8%)	76(96.2%)	2.361[.849, 6.564]	0.211
Second	19(23.2%)	63(76.8%)	0.601[.276, 1.311]	0.016
Third	15(19.5%)	62(80.5%)	0.802[.354, 1.819]	0.059
Fourth	10(12.3%)	71(87.7%)	1.015[.438, 2.350]	0.46
Richest	7(8.8%)	73(91.2%)	1	

[*p-value < 0.05]

5.6. Health institutions and pattern of client-provider interaction

Bivariate logistic regression showed that public and private for profit health facilities appeared to be statistically associated with client-providers interaction. The result showed that public health facilities had 0.043 (95%CI: 0.018, 0.103) and private for profit clinics had 0.025 (95%CI: 0.009, 0.073) less likely to have GCPI as compared with NGO institution (Table-6).

Table 6 Types of health facilities and good client-provider interaction in public, NGO and private health facilities in Adama Town, October 2013, Adama Ethiopia.

Categories	Numbers (%)	COR95%CI	P-

	PCPI	GCPI		**value**
Public health facilities	33 (37.1%)	56 (62.9%)	0.043(.018, .103)	0.000
NGO	7 (2.5%)	275 (97.5%)	1	
Private for profit	14 (50%)	14 (50%)	0.025(.009, .073)	0.000

[P<0.001]

Chapter 6 Discussion

This study was conducted to assess client-providers interaction through observation of CAC service provision in selected health facilities in Adama special Administrative town. In this study observation of the interaction of service providers and clients showed that 83.2% of the cases had got good client-provider interaction (GCPI) for client-provider interaction items. Among this, 53.9% of the cases were for public health facilities (hospital and health centers), 95.7% were for NGO clinics and 50% were for private for profit clinics. This result indicated that provider from NGO sectors interacts better with client than provider from public sectors and private for profit sectors in many items of observation. In particular, issues of greeting client respectfully, use of IEC material during client consultation/education session, ensuring client privacy, listening patiently to client need/concern, provision of information on the need of contraceptive were not addressed in public and private for profit sectors to the same extent to NGO sectors. These might be due to difference in training and NGO physical space

In this study there was no significance difference indicated in provider and client interaction for public and private for profit sectors. In contrast to this study observation of the consultation conducted in Ghana revealed that provider from private sectors interacts better with client than provider from public sectors in many items of observation [10]. This might be showing an improvement in provider awareness and difference in study design.

In this study showed that majority of public (91%) of the cases, the providers did not greet to the client respectfully which very low as compared to the study conducted at private for profit institution in Addis Ababa which revealed interaction of providers and client that evaluated during observation of client showed that 96.1% of clients were greeted politely[34]. This difference might be due to less patient overload in private health institutions where service providers get more time to interact with the clients.

In this study providers used IEC material during consultation for 30.6% clients which is relatively high as compared to the study conducted in private for profit institution in Addis Ababa which revealed for 14.5% of client [11]. This might be showing an improvement in terms of provider awareness to give better information to client but still needs immense attention.

With regard to information pertaining to complications or danger signs only 40.4% of cases were told to revisit the facility if the danger signs happens in all health facilities (50.5% for public health facilities, 36.6% for NGO and 35.7% for private for profit clinics) is relatively high as compared to a study done in governmental health facilities in Guraghe zone (34.5%) [12]. This result showing an improvement in term of service provider awareness about the importance of providing this information from time to time but still needs immense attention.

In this study privacy maintained (87.6% for public and 100% for private for profit clinics) and ensured confidentiality (37.1% for public and 46.5% for private for profit clinics) similar as compared to the study conducted in public and private for profit health facilities in Ghana which revealed that providers were ensured client privacy (36.8% for public and 98.7% for private) and assured client confidentiality (17.6% for public and 96.1% for private) [10]. This might be due to difference in case load in public and private for profit and physical space.

Future unwanted pregnancies can be avoided if abortion seeking clients are provided information on how to avoid or prevent such pregnancies. In this study providers provided family planning counseling for 92.2% clients and for 81.5% of client provided or prescribed/linked to family planning site (clinics) which relatively high as compare to result obtained from a study done at public and private health facilities health facility in Dessie which revealed that 56% of client have got family planning counseling and 47.5 % of client provided with modern contraceptive method and for 78% post abortion women in study from Tigray region[35, 36]. This difference might be due to an improvement in service providers' awareness on provision of family planning information and counseling and method provision.
Similar to previous study [37], in this study high level of education status was associated with good client-providers interaction. This might be due to educated women being aware of the service that enhances their communication skill to get more information from providers.

The majority of the service providers' (94.4%) were trained on basic CAC services and 55.6% of service providers attended refreshment training. Although lower in proportion, the negative attitudes towards dealing with cases of safe abortion among service providers deserve an immense attention.
In conclusion the study has identified key areas that need improvement to make CAC better in the study facilities. IEC efforts and the client-providers interaction need to improve. Provider

training should emphasize to enhance their existing skill toward client interaction and attitude towards dealing with cases of safe abortion.

6.1 Strength and weakness of the study

The strength of the study; the study has considered different assessment techniques such as patients and provider's perspective service observation. And the study has focused on public, NGO and private for profit health facilities and gave picture of all health facilities.

This study also has some weaknesses. During the service observation there could be a tendency by service provider to be at their best performance due to the presence of an observer. Social desirability bias is also likely in this study as a respondent were interviewed in the compounds of the health facilities.

Chapter 7. Conclusion and recommendation

7.1 Conclusion

Client-providers interaction as was seen from provider perspective is good. However, from a clinical service delivery stand point, important information on assuring confidentiality, how to do self care to their client, possible occurrence of pregnancy immediately after abortion, use of IEC materials (models, diagrams) during client counseling/education session and greeting the client respectfully were neglected during client-provider interaction. A large proportion of cases had good client-providers interaction. NGO clinics had better client-provider interaction scores compared to public health facilities and private for profit clinics. Clients who were primary school completed had less client-provider interaction than 10+1 and above. A majority of the service providers had taken training. Although lower in proportion, the negative attitude towards dealing with cases of safe abortion among service providers.

7.2. Recommendation

Based on the finding of the study the investigators recommended the following:

1. There is a communication gap between providers and clients that leads poor client-providers interaction, so service providers improve the way of conveying information to and from clients.-
2. Service providers should encourage clients to ask questions they are uncertain or do not understand some issues. Part of quality of care is to allow clients to ask question to service providers and clarify confusions. This situation needs to be improved especially in public and private health facilities.
3. In all health facilities service providers should ensure confidentiality of the clients.
4. In all of the six service delivery points service providers should use IEC materials (models, diagrams) during client counseling/education session.
5. In all of the six service delivery points service providers should be improved informing the client about the benefit and possible side-effect of each procedure.
6. Public health facilities (Hospital and health centers) should improve procedure room. The room needs to be ventilated, toile facilities near to procedure room and necessary equipment in the room.

11. References

1. Family Planning Association of Nepal Central Office. Facility Survey on Safe Abortion in Six Clinics of Global Comprehensive Abortion Care Project. *Pulchowk; Kathmadu; Nepal, February, 2009*
2. David A Grimes, et al. Unsafe Abortion. The Preventable Pandemic. October 2006; Vol.4. Available: http://www.who.int/reproductive-health. Accessed: September 2013.
3. Susan A. Cohen. Facts and consequences: Legality, Incidence and Safety of Abortion worldwide. Guttmacher policy review 2009; Vol. 12. Number 4.
4. FMoH. Technical and Procedural Guideline for safe abortion service in Ethiopia. Addis Ababa; FMOH. 2006.
5. Yusuf, J. Assessment of risky sexual behavior for HIV infection in Birhany Lesefu. (EPHA, 2003/2004:31-37)
6. Fasika Ferede. Minors' Awareness about the New Abortion Law and Access to Safe Abortion Service in Ethiopia: The Case of Marie Stops International Ethiopia centers in Addis Ababa. Amsterdam; University of Amsterdam. August 2010.
7. Girma S, et al. Human Resource Development for Health in Ethiopia challenges of achieving the millennium Development Goals. Addis Ababa, *Ethiopia J Health Dev*: 2007.
8. Susheela S. al.et. The Estimated Incidence of induced abortion in Ethiopia. Guttmacher institution March 2010; vol.36.
9. PATH. Improving Interaction with client: A Key to High quality services. Washington. Available:www.path.org. Accessed: January 2013.
10. Philomana et al. Profile of Abortion Seeking in Ghana and their decision making process. University of Ghana, Legeon; 2008.
11. Tigest G/Egizibher and yilmaMelkamu, Quality of reproductive health service at Private for profit institution in Addis Ababa. May 2007, Vol. 2(1) Ethiopian Journal of Reproductive Health: 2008.
12. Gezahegn Tesfaye and Lemessa Oljira, Post abortion care quality status in health facilities of Guraghe zone, Ethiopia: 2013.

13. Jemila Abdi and Mulugeta B gebremariam, health providers' perception towards safe Abortion Service at Selected health Facilities in Addis Ababa. Afr J Reprod Health 2011; 15(1): 31-36.
14. De Geyndt W. Managing the quality of health care in developing countries. World Bank Technical Paper 1995, 258:80.
15. John M, Robert R, and Gilbert E. Patient-Physician Communication: Why and How. 2005; 105(1). *Available: http://www.jaoa.org/cgi/.* Accessed: Dec. 2013.
16. M. Berrer. Making abortion safe: A matter of good public health policy and practice. The International Journal of Public Health, Special Theme: Reproductive health. Geneva; WHO: 2000; 78(5): 569-714.
17. IPAS. Advances in Abortion Care. Corrboro, CN: IPAS, 1994; 4(1): 4.
18. Federal Democratic Republic of Ethiopia, Ministry of health, Health sector development program IV, Annual performance report, 2009/2010. P 37-38
19. Singh S. Fetters T. Gebreselassie H., The estimated incidence of induced abortion in Ethiopia, International Perspectives on Sexual and Reproductive Health, J. of reproductive health, March 2010, 36,(1), 16-25
20. WHO. Country Cooperation Strategy at a glance: Federal Democratic Republic of Ethiopia. Available: http*;//www.afro.who.int/en/ethipia/countrycooperation*.Accessed: August 2013.
21. Improving Interpersonal Communication between Health care Providers and Clients, Wisconsin Avenue, USA. Available:www.urc-chs.com. Accessed: Dec 2013
22. Khan AA. Non-Verbal communication: Fact and Fiction. 2001. Available: *http://www.strangehorizons.com/2001/20010226/nonverbal.shtml*. Accessed: 10/11/2013.
23. Lowell A. Communication and Cultural Knowledge in Aboriginal Health care: a review of two subprograms of Cooperative research Center for Aboriginal and Tropical Health's Indigenous Health and Education Research Program. CRCATH; 1998.
24. Ong LM, de Haes JC, HoosAM, Lammes FB. Doctor-patient communication: a review of the literature. Soc Sci Med; 1995; 40(7):903-18.
25. Lori Asford and Carolyn Makinson. Reproductive Health and Practice: Case Studies from Brazil, India, Morocco, and Uganda. Washington, DC: Population Reference Bureau; 1999.

26. Murphy EM. Best practices in client-provider interactions in reproductive health services: a review of the literature. MAQ Initiative. 2001.
27. Gabe J, Bury M, Elston MA. Key concepts in medical sociology. London, Thousand Oaks: *Sage Publication; 2004*.
28. Scambler G. Sociology as applied to medicine. 5th edition. London, New York, Philadelphia, St Louis, Sydney, Toronto. 2003.
29. Barry CA, Bradley CP, Britten N, Stevenson FA, Barber N. Patients' unvoiced agendas in general practice consultations: qualitative study. Brit Med J. 2000;320:1245–50
30. Amanuel Gessessew, Unwanted pregnancy and it's impact on maternal health and utilization of health services in Tigray Region (Adigrat Hospital). 2009; 47(1):1-8. Available: Ethiopia: *Ethiopian medical journal.* Accessed: September 2013.
31. WHO, Safe abortion techniques and policy guidance for health system. Geneva, WHO, 2003.
32. Census Statistics Agency of Ethiopia; 2007.
33. IPPF. Comprehensive Abortion Care: Guidelines and tools for Clinic. 4 New hams London, Unit kingdom, IPPF. Available: *www.ippf.org*. Accessed: August 2013
34. Solomon Kumbi, Yilma Melekamu, Hailu Yemeneh, quality of Post Abortion Care in Public Health facilities In Ethiopia. Addis Ababa, Ethiopia; Ethip J. health Dev 2008; 22(1)
35. Awel Seid, Abebe Gebremariam, Mulumebet Abera, Integrating of family Planning Services Within Post Abortion Care at Health Facilities in Dessie-North east Ethiopia. Jan-March 2012, 1(1): 38-46. Available: www.starjournal.org. Accessed: January 2014.
36. IPAS. Reducing unsafe abortion in Ethiopia monitoring progress with the Safe Abortion care (SAC) model in Tigray. Chapel Hill, IPAS. Available: http://www.ipas.org/Publications/asset-upload_file 570_4687.pdf. Access: January 2013.
37. Berhanu et al. Determinant of satisfaction with care provider interaction at health centers in center Ethiopia. BMC health service Research, Ethiopia, 2010.

12. Annex

Annex 1 Checklist used for Observation

QUESTIONNAIRES

COLLEGE OF PUBLIC HEALTH & MEDICAL SCIENCE

DEPARTMENT OF HEALTH SERVICE MANAGEMENT

Facility based client-provider interaction assessment checklist, September 2013, Adama, Ethiopia.

Direction: observational check list on the following items

PART 1: observation of client-provider interaction in safe abortion service provision to Client

Code of the client__________________ Code of the service provider__________________

Data collector: - Name ______________________ code data collectors____________________

100. Name of the Health facility _______________________________________

	Section—1	
101	Is service provider greeting the client respectfully? (if provider greeting client standing from his chair or sitting and inviting the client to site with or without shaking the client)	1. Yes 2. No
102	Is service provider give the client the opportunity to see him alone/privacy/? (provider allowed the client to see him alone , if any partner/career are presented with her order them to be outside examination room or with permission client if not and closing the door)	1. Yes 2. No
103	Is service provider listening patiently to client's needs/concerns without interrupting her to answer her question correctly?	1. Yes 2. No
104	Is service provider uses language that the client understands easily? (if the provider communicate using the same language or using interpreter of language to the client without mixing any language)	1. Yes 2. No
105	Is service provider uses language that supportive of the client's decision (not judgmental)? (provider information intend to help client to understand and make her own informed decision making that is not on pre-determined course action)	1. Yes 2. No
106	Is service provider assuring client confidentiality? (provider assuring for client that her information is not disclosed to other without her permission or ordered by a court of law)	1. Yes 2. No

107	Is service provider provides information to the partner or the carer (if present) on how to support the client?	1. Yes 2. No
108	Is the service providers explaining the CAC services available (medical & surgical) in the health facilities to their clients?	1. Yes 2. No
109	Is the service provider explaining abortion procedure to client? (provider providing information and counseling about safe abortion care procedure that client will be receiving)	1. Yes 2. No
11 0 **110.1** **110.2** **110.3** **110.4** **110.5** **110.6** **110.7** **110.8** **110.9**	If yes to question 109, Which procedure does the service providers explaining? Explain how long the procedure will take? Explain pain medication procedure? Explain benefits of the procedures? Explain possible side-effects of the procedure? (eg. Pain, bleeding, nausea, diarrhea and vomiting) Explain recovery time and when to resume normal activity (including sexual activities)? Explain possible complication and where to go for treatments? Explain about the need of contraceptive use? Explain the need for follow up? Explain other tests if any are to be performed (blood, urine, etc)?	1. Yes 2. No 1. Yes 2. No 1. Yes 2. No 1. Yes 2. No 1. Yes 2. No 1. Yes 2. No 1. Yes 2. No 1. Yes 2. No 1. Yes 2. No 3. NA
111	Does the service provider encouraging client to ask questions and they responded to clients' questions correctly? (provider allow sufficient time to the client to ask question and express their fear and to answer their questions)	1. Yes 2. No
112	Does service providers allow client to make her own choice of the services available? (provider allow client to make decision freely after counseling and consent to the procedure of termination in written)	1. Yes 2. No
113	Does the service provider use IEC materials (models, diagrams) during client counseling/education session?	1. Yes 2. No
114	Is the service providers inform clients of referral and follow up protocols after the procedure (e.g. what to expect, what she can and cannot do, emergency numbers)?	1. Yes 2. No
115	Is the service provider direct the client where to go after procedure? (provider direct client to post recovery room or rest site before discharge)	1. Yes 2. No

116	Is the service provider follows up the client after the procedure in the recovery room or rest site?	1. Yes 2. No
117	Is the service providers provide information to client how to care herself at home?	1. Yes 2. No
118	Is the service provider recaps on information given at the beginning of the session?	1. Yes 2. No
119	Is the service provider offered a modern Family planning method to client? (if the provider, provide or prescribe choice method contraceptive to client or link or referred to family planning service clinics)	1. Yes 2. No

Annex 2 Questionnaire Designed for provider Interview (English)

Direction: provider interview questionnaires

Code of the service provider ___________________

Data collector:-

Name _______________________ code data collectors___________________

1. Name health facility ____
2. Total number of health service provider in your health facility__________________________________
   1. Physician________________
   2. Nurse_____________________
   3. Midwife______________________
   4. Health officer___________________
   5. Other, (specify)______________
3. Total Number of health professional trained in CAC _____________________
   1. Physician________________
   2. Nurse_____________________
   3. Midwife______________________
   4. Health officer___________________
   5. Other, (specify)______________
4. When did CAC service started in your health facility _______________________________
5. Is there specific safe abortion services provider assigned_____________________________
6. What is the average rate safe abortion service user per week__________________________

Section -3		
301.	Sex	1. Male 2. Female
302.	Would you tell me, what is your profession?	6. Physician 7. Nurse 8. Midwife 9. Health officer

		10. Other, (specify)_____
303.	What is your age	_______________
304.	Marital status	1. Single 2. Married and Living together 3. Married , but not living together 4. Divorced 5. Widowed 6. No steady partner 7. Other (Specify)____________
305.	What is your religion?	1. Muslim 2. orthodox 3. protestant 4. other
306.	When did you complete your basic education?	1. Less 10 years 2. 10-20 years 3. More than 20 years
307.	What is your working experience in current facility?	_________years ________months
308.	Have you been trained in CAC service provision?	1. No 2. Yes
309.	If yes, to question 308, What kind of training was it?	1. PAC with MVA 2. CAC using MVA 3. CAC using medical abortion 4. CAC using MVA and medical abortion 5. Not applicable
310.	When did you trained? (duration of training)	1. Before one year 2. within this year's (not more than one years) 3. not applicable
311.	Have you any refreshment training related to reproductive health services?	1.yes 2. no
312.	If yes to question 311, what kind of refreshments training?	1. CAC 2. FP 3. STI 4. HIV/AIDS 5. Other (specify)_________________________

313.	Did women who want safe abortion service (termination of pregnancy) should be provided?	6. Yes 7. No 8. No comment 9. No response
314.	Are women who came for safe abortion service should deserve equal attention to other women seeking medical attention?	1. Yes 2. No 3. No comment 4. No response
315.	Are you comfortable dealing with safe abortion case? (Providing safe abortion services)?	1. Yes 2. No 3. No comment 4. No response
316.	Are married women, unmarried and adolescent girls should be treated equally? (for providing safe abortion services)	1. Yes 2. No 3. No comment 4. No response
317.	Have you ever performed TOP/PAC (CAC) services?	1. Yes 2. No 3. Not applicable
318.	If yes to question 317, how often do you currently perform TOP/ PAC (CAC) services?	_______________Convert to times per month: ____________
319.	How many cases did you perform per week?	_________________________________
320.	What methods do you use to perform CAC [Multiple responses possible]?	1. MVA 2. MA (Misoprostol PLUS mifeprostol) 3. MVA and MA 4. Sharp Curettage/D&C 5. Other, specify_____________________________ 6. Not applicable
321.	For how long have you been involved in CAC services [MA/MVA] generally?	____years ____months [Enter months only if total time is less than one year; otherwise round to nearest year]
322.	For how long have you been involved in CAC services [MA/MVA] at	____years ____months [Enter months only if total time is less than one year; otherwise round to nearest year]

	this facility?	
323.	What do you think are the barriers for implementation of CAC services in this facility?	1. Work overload because there is not enough staff to run the clinic 2. Lack of training on provision of CAC 3. Lack of skill in counseling 4. Lack of time for counseling 5. There is no willingness/ commitment among staff to provide abortion services 6. There are negative attitudes among staff towards abortion 7. Lack of confidence in handling side effects among staff 8. No proper referral mechanism between this facility and the hospital 9. Women won't want this type of service 10. Lack of drugs 11. Too costly 12. Other, explain ________________________________

Annex 3 Questionnaire Designed for Exit Interview (English)

Client exit interview questionnaires

Section -2 background information		
201.	How old are you?	_____ years
202.	Where is your Residence?	1. Urban 2. Rural
203.	What is your highest level of education?	1. Illiterate 2. Write and read 3. Primary school [1-8] 4. Secondary school completed 5. Twelve/10 +1 and above 6. Don't know/Refused
204.	What is your relationship status? ***Interviewer: Please read all answers and mark the one that best describes the interviewee's relationship status***	1. Single 2. Married and Living together 3. Married , but not living together 4. Divorced 5. Widowed 6. No steady partner 7. Other (Specify)______________

205.	What is your Ethnicity?	1. Oromo 2. Amhara 3. Gurage 4. siliti 5. Other
206.	What is your religion?	1. Muslim 2. orthodox 3. protestant 4. other
207.	What is your occupation?	1. Government employee 2. Private employee 3. Merchant 4. Unemployed 5. House wife 6. Student 7. Daily laborer 8. Prostitute 9. Other (specify) ____________
208.	What is your monthly income?	______________Eth.birr
209.	What is your occupation status? Please choose the category that best describes client main job. If no one of the categories fits exactly, please categories to closest category of your experience. (select only one)	1. Executive, administrator, or senior manager (e.g., CEO, sales VP, plant manager) 2. Professional (e.g., engineer, accountant, systems analyst) 3. Technical support (e.g., lab technician, legal assistant, computer programmer) 4. Sales (e.g., sales representative, stockbroker, retail sales) 5. Clerical and administrative support (e.g., secretary, billing clerk, office supervisor) 6. Service occupation

		(e.g., security officer, food service worker, janitor) 7. Precision production and crafts worker (e.g., mechanic, carpenter, machinist) 8. Chemical/Production Operator (e.g., shift supervisors and hourly employees) 9. Laborer (e.g., truck driver, construction worker) 10. Farmer (Ex. Use ox, tractors, others) 11. Unemployment
210.	What is your husband occupation status? Please choose the category that best describes your husband/family main job. If no one of the categories fits exactly, please categories to closest category of your experience. (select only one)	1. Executive, administrator, or senior manager (e.g., CEO, sales VP, plant manager) 2. Professional (e.g., engineer, accountant, systems analyst) 3. Technical support (e.g., lab technician, legal assistant, computer programmer) 4. Sales (e.g., sales representative, stockbroker, retail sales) 5. Clerical and administrative support (e.g., secretary, billing clerk, office supervisor) 6. Service occupation (e.g., security officer, food service worker, janitor) 7. Precision production and crafts worker (e.g., mechanic, carpenter, machinist) 8. Chemical/Production

		Operator (e.g., shift supervisors and hourly employees) 9. Laborer (e.g., truck driver, construction worker) 10. Farmer (Ex. Use ox, tractors, others) 11. Unemployment
211.	What is your water source of drinking?	1. Rain water 2. Pond/lake /dam 3. River 4. Open spring 5. Open well 6. Covered spring 7. Covered well 8. Piped outside compound 9. Piped inside compound 10. Others __________
212.	What is your toilet facility type?	1. No facility /bush/field 2. Traditional pit latrine 3. Improved ventilated pit latrine 4. Flush toilet 5. Others________
213.	Is their electricity service in your house?	1. Yes 2. No 3. Other
214.	Does your family possess radio?	1. Yes 2. No 3. Other
215.	Does your family possess television?	1. Yes 2. No 3. Other
216.	What is the main material of your house floor?	1. Earth / sand 2. Dung 3. Wood planks 4. Parquet 5. Vinyl sheets/tiles 6. Cements 7. Cement tiles/brick(and covered with plastics) 8. Carpet (“keesha”) 9. other

217.	What is roof material of your house?	1. Wood/mud 2. Plastic sheet 3. Mobile roof 4. Iron sheet 5. Cement 6. Other
218.	What are types of fuel used for cooking?	1. Dung 2. Firewood 3. Charcoal 4. Kerosene 5. Biogas 6. Natural gas 7. Electricity 8. other________________

Annex 4 Questionnaire Designed for Exit Interview (Oromifa)

GAAFFILEE –OROMIFFAAN KAN QOPHAA'E

YUUNVARSTII JIMMAATTTI KOOLEEJJII FAYYAA

HAWAASA FI SAAYINSII YAALAA

DIIPAARTIMANTII HOOGGANSA TAJAAJILA FAYYAA

Gaaffile tajaajilamitota tajaajila argatanii bahaniif

Lakk. Kodii tajaajilamaa ------------

Gaaffii Gaafataa: -

Maqaa______________________ Kodii gaafataa__________________

200. maquaa Dhaabata Fayyaa itti guutame __________________________________

Section -2 Hala waliigalaa		
201.	Ummuri kee meeqaa?	Waggaa _____
202.	Bakka jireenyaa?	1. **B**adiyya 2. Magaalaa
203.	Sadrkaan barumsaa keetii?	1. kan hin baranne 2. barresuu fi dubbisuu 3. sadarkaa tokkoffaa [1-8] 4. sadarkaa lammafaa(9-12) 5. kutaa 12 +1 fi isaa ol 6. hin beeku

204.	Haalli gaa'ila keetii maalii?	1. kan hin erumnee 2. kan erumeefi walin jiraatan 3. kan erumefi waliin hin jiraanne, 4. kan hikte 5. kan jalaa du'tee 6. kan hin erumneefi hiriyaa dhabbi kan hin qabnee 7. Kan biro__________________
205.	Sabni atii irraa dhalatee maali?	1. Oromo 2. Amhara 3. Gurage 4. siliti 5. kan biro____________
206.	Amantaan kee maali?	1. Muslima 2. Orthodoksii 3. Protestaantii 4. kan biro
207.	hojjii kee malii ?	1. hojataa motumaa 2. hojataa dhunfaa 3. daldaalaa 4. hojataa kanhintanee 5. ada manaa (House wife) 6. baratuu 7. hajetaa guyyaa 8. hojetuu mana bunaa (Prostitute) 9. kan biro Other ____________________________
208.	Galiin keessan kan ji'aa meeqaa ?	Birrii ---------------
209.	Haala hojjii Haadha warraa kan sirriti ibsuu filadhuu	1. Hogganaa, gaggeessaa olaana , ogeessa olannaa (e.g., CEO, sales VP, plant manager) 2. Oggeessaa

		(e.g., engineer, accountant, systems analyst) 3. Oggeessa teekinikaa (e.g., lab technician, legal assistant, computer programmer) 4. Daldaalaa (e.g., sales representative, stockbroker, retail sales) 5. Haala mijeessa waajiraa fi suparvazara (e.g., secretary, billing clerk, office supervisor) 6. Gaggeessaa hojii (e.g., security officer, food service worker, janitor) 7. Hojeetaa ogummaa techinikaa (e.g., mechanic, carpenter, machinist) 8. Hojjetaa guyyaa /hojjeta sa'atii (e.g., shift supervisors and hourly employees) 9. Hojetaa humna (e.g., truck driver, construction worker) 10. Qotee bulaa Eg .Use ox ,tarctor ,other 11.Kan hoji hinqabnee
210.	Haala hojjii Abbaa warraa kan sirriti ibsuu filadhuu	1. Hogganaa, gaggeessaa olaana , ogeessa olannaa (e.g., CEO, sales VP, plant manager) 2. Oggeessaa

		(e.g., engineer, accountant, systems analyst) 3. Oggeessa teekinikaa (e.g., lab technician, legal assistant, computer programmer) 4. Daldaalaa (e.g., sales representative, stockbroker, retail sales) 5. Haala mijeessa waajiraa fi suparvazara (e.g., secretary, billing clerk, office supervisor) 6. Gaggeessaa hojii (e.g., security officer, food service worker, janitor) 7. Hojeetaa ogummaa techinikaa (e.g., mechanic, carpenter, machinist) 8. Hojjetaa guyyaa /hojjeta sa'atii (e.g., shift supervisors and hourly employees) 9. Hojetaa humna (e.g., truck driver, construction worker) 10. Qotee bulaa Eg .Use ox ,tarctor ,other 11.Kan hoji hinqabnee
211.	Maddi bishaan dhugaatii keeti maali?	1. Kan roobaa 2. Haroo/bishaan kuufame 3. Laga 4. Bishaan burqaa banaa 5. Bishaan boola banaa 6. Bishaan burqaa dalai qabuu 7. Bishaan boola dalai qabuu

		8. Bishaan boonuu moraan alaa 9. Bishaan boonuu mooraa keessaa 10. Kin biro
212.	Manni fincaani kee maali?	1. Hinqabuu 2. mana fincaani adaa 3. mana fincaani adaa foyya'aa 4. Mana ficaanii bishanii irraa dhiqu qabu 5. kan biroo______
213.	Ibsaan elektirikaa ni mana kessan jira?	1. Eyyee 2. lakki 3. Kan biroo
214.	Maatiin kee radiyoo ni qabuu?	1. eyyee niqabu 2. hin qabanii 3. Kan biroo
215.	Maatiin kee televiziyoona ni qabuu?	1. Eyyee 2. lakki 3. Kan biro
216.	Dacheen mana kessanii maali irraa hojjatame?	1. Laafaa ykn dhagaadha[sand] 2. Dhoqeen dibame 3. Mukaan tolfame 4. Xaawulaan tolfame 5. Plastikaan uwifame 6. Siibintoon uwiifame 7. Sibintoon uwifami plastic qaba 8. Keeshan uwifame 9. Kan birroo
217.	Baxiin mana kessani maal?	1. Muuka/dhoqeen 2. plastiika 3. baaxi socha'aa 4. Qorqoorodha 5. simmintoo 6. Kan birroo
218.	Nyaata bilchefachuuf annisa maali fayyadamta	1. faltii horii 2. muuka 3. kasala 4. gazii adii 5. Biogaazii 6. gazii umamaa 7. humna ibsaa 8. Kan birroo

Annex 5 Informed Consent (English)

Introduction and Consent

CONSENT FORM

Good morning!

My name is ____________________________, I am a student of Jima University Masters in Health Service Management. I'm currently doing a study on assessment of client-provider interaction in safe abortion service in Adama town with the main objective to provide information on the quality client-provider interaction that helps to meet quality of care standards on safe abortion care in all public and private health facilities found in Ethiopia, particularly in Adama town. As the study is directly related to women of reproductive group (15-49 years) you are one of the women who are selected to participate in this study. Therefore you are kindly requested to participate in this interview. I am going to ask some very personal questions, your participation in this interview is completely on voluntary bases and you have the right to refuse the participation. You have the right to withdraw from the interview at any time or refuse to answer any questions you feel uncomfortable about. The information you provide will be kept confidential. This study will not provide you any direct benefits, but the information that you provide are very essential, not only for the successful accomplishment of the study but also for producing relevant information which will help in improving the provision of the service. All the information in the interview will be held in strictest confidence. I will not ask your name, address, or identification number

Are you willing to participate in the interview?

- yes, go to the next page
- No, Thank them and interrupt the interview

Annex 5 Informed consent (Oromifa)

Seensa fi feedhii hirmaachu tajajilamtoota argachuu

Nagaa jirtuu! Maqaan koo ________________ jedhama. Ani koree qoranno Yuunivarsitii Jimma Koolejjii Fayyaa Hawaasaa fi Saayinsii Yaala baruumsa digrii lamaffaa keessa hojjedha. Kaayoon qorannoo kana walquunamti tajajilamtoota fi ogeesoota fayyaa motumaa keessatti tajajila ulfa baasuu haadholeef keennama jiru xinxaalufi . Qorannon kun kan kalatiidhan ilaalatu haadholee tajaajila ulfa basuu fudhataa jirani dha. Isinis namoota qoranno kana keessatti akka hirmaatan filataman keessaa tokkodha. Kanafu isin ilee qoranno kana keessatti hirimaatanii raga isin irraa barbaadamu hundaa akka keennitan isin afeera. Hirmaanan keessan guutuman gutuutti feedhii keessan irratti hunda'a kanafu yoo fedhii hinqabanee dhisuu ni dandeesu. Ragaan ykn Deebin isi naaf keennitan icitiin eegama namituu hinhimamau.

Ragaa qoranno kanaaf keennitan tajaajila dhabilee fayyaa sana keessatti keennamu fooyyessuf gahee oli aanaa qaba, Kanfuu qorannoo keenya keessatti hirmaachu ni feetuu?

Eeyee --------------- Lakkii -----------------