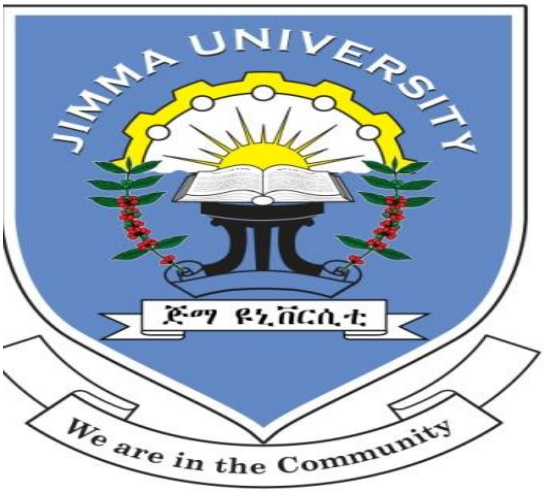


JIMMA UNIVERSITY

COLLEGE OF HEALTH SCIENCE

DEPARTMENT OF HEALTH ECONOMICS MANAGEMENT AND POLICY

HEALTH MONITORING AND EVALUATION UNIT

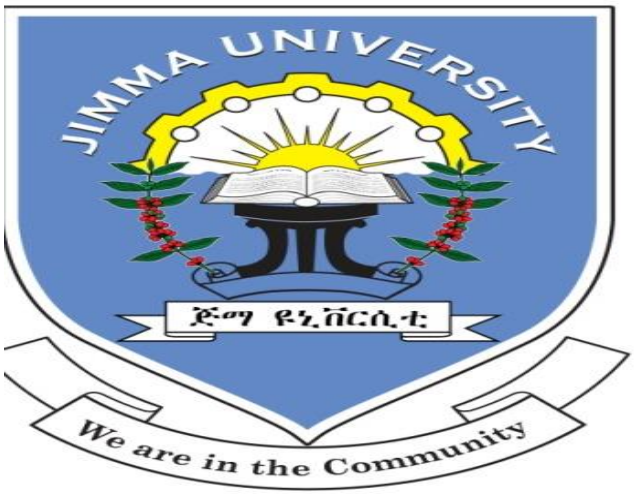
PROCESS EVALUATION OF LONG ACTING FAMILY PLANNING PROGRAM IN PUBLIC HEALTH FACILITIES OF SORO DISTRICT, HADIYA ZONE, SOUTHERN ETHIOPIA

PRINCIPAL EVALUATOR

YOSEPH NIGUSSIE (BSC.)

JUNE, 2016

JIMMA, ETHIOPIA



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An Evaluation thesis to be submitted to Jimma University, College of Health Science, Department of Health Economics Management and Policy, Health Monitoring and Evaluation Unit for Partial Fulfillment of Degree of Masters of Sciences in Health Monitoring and Evaluation

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June, 2016

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Abstract

Background*:* *Long-acting family planning is a low-cost yet effective way to lower maternal mortality by reducing the number of high-risk births. These methods can enhance family planning programs in meaningful ways if challenges to their availability, access, and acceptability can be overcome. Yet several strong barriers persist in sub-Saharan Africa including Ethiopia, the availability of materials and equipment and trained health provider were some of the limitation for the program. This evaluation research was intended to assess the implementation of long acting family planning service provision and show the areas of improvement for future implementation.*

Objective: *the objective of this process evaluation was to assess the implementation status of long acting family planning program in public health facility of Soro district, Hadiya Zone, 2016.*

Method: *A facility based case study design with quantitative and qualitative data collection methods was employed with all health centers and randomly selected 30% health posts of Soro district from March 07- April 5, 2016. The evaluation was focused on process part of the program with dimensions; availability, compliance and client satisfaction in the dimension of accommodation. Resource inventory, document review; key informant interviews and observations were conducted. Client satisfaction was assessed through exit interview; with sample size of 381. The qualitative data was analyzed manually using thematic analysis and quantitative data were analyzed by using SPSS version 20 software. Bivariate and multivariate logistic regressions were done to determine the predictor of client satisfaction. The finding of this evaluation were computed and compared with preset criteria for the final judgment.*

Result: *Majority of the health facilities were had only one trained health care providers (78.6%) on long acting family planning. Around 59% and 39% of the health facilities were have light source and taped water respectively. Only one health facility has separate room for family planning and about 30% health facilities were had National FP guideline. About 66% of the required resources for provision of long acting family planning were available which was **FAIR** in judgmental. The data were collected from 381 respondents. Clients were informed about the methods only 61.4% client told the possibility of switching. The result for compliance was fallen under category of **GOOD** in score of 76.4%. About 61% of the clients were satisfied on service provided by public health facilities of Soro district. Distance travel, education level, frequency of visit and plan when to have the next child were predictors of client satisfaction with **FAIR** in judgmental.*

Conclusion and Recommendation: *the overall implementation of long acting family planning service in public health facilities of Soro district was **FAIR** with the overall achievement in three dimensions was **70.8%** pre-sated agreed judgment criteria during evaluability assessment. It is recommended that, to stop malpractice provision of the service by untrained provider, access health facilities to basic infrastructures and other recommendations to improve the program.*

Key words: *Long acting family planning, Case study, client satisfaction, Soro district.*

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Acronym and abbreviations

AHA	African Humanitarian Action
CRHA	Community Reproductive Health Agents
EA	Evaluability Assessment
FGAE	Family guidance Association Ethiopia
FHI/360	Family Health International 360
FMOH (MOH)	Federal Ministry of Health Ethiopia
FP	Family Planning
HDA	Health Development Army
HEP	Health Extension Program
HEWs	Health Extension Workers
HFs	Health Facilities
HSDP	Health Sector Development Program
HSTP	Health Sector Transformation Plan
IEC/BCC	Information Education communication/ Behavioral change communication
IFHP	Integrated Family Health Program
IPPF	International Planned Parenthood Federation
IUD/IUCDs	Intrauterine contraceptive Devices
LAPMs	Long Acting and Permanent Methods
LARC	Long Acting Reversible Contraceptive
MDG	Millennium Development Goal
NGO's	Non-governmental organization
SDP	Service Delivery Point
SNNPR	Southern Nation Nationality and People Region
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization

Operational Definition

Long-term family planning: are defined as those methods that prevent pregnancy more than or equals to three years per application (Implants, IUCD, male and female sterilizations).

Short term users: those clients who have been using Depo-Provera, Pills, diaphragm and condoms.

Unmet need for long acting FP: - A condition of wanting to postpone or avoid pregnancy but not using any of the long acting FP or using short acting contraceptive but do not wants to use the method that they were using.

Demand for long acting FP: is the sum of current use of long acting contraceptive methods (met need) and the method desired but not used due to any reason (unmet need)

Accommodation: - this dimension is assessed through clients' perspective /client view/ that the state of being satisfied about the manner in which the health facility organized resources including infrastructures to accept client.

Client Satisfaction: This is clients' opinion/perception about the service readiness to provide LAFP after received the service. In this study the satisfaction level was used to measure the level of client satisfaction on accommodation (satisfaction level).

Waiting Time: The time gap between the client's arrival at the SDP and the time the client received FP services. *Acceptable waiting time*: <30 min *and unacceptable waiting time*: > 30 min.

Availability resources: Health care staff needs reliable, sufficient inventories of supplies, instruments, and working equipment, as well as the infrastructure necessary to ensure the uninterrupted delivery of high-quality services.

Appropriate storage of contraceptive: means no exposure to rain and sun, protected from rats and pests and not subjected to extreme heat.

Privacy: mean protect the client by having a separate room for examination and clinical procedure, or by having an area closed in by a curtain protect client from visual and auditory.

Waiting area: which provides a roof or other shelter protect from sun and rain, the waiting area is sheltered to have seating if there are chairs, benches, or seating along a wall for clients such that clients are not sitting directly on the ground.

Report consistency: is the way which health facilities documented activity on registration log book/ integrated card similar to the reported and service delivery tally sheets if available.

Basic information: information provided to the clients during counseling that was important to help the client to decide which method of FP will be suitable to her, this information constitute (side effect, advantage and disadvantage, possibility of switching, how the method work, what to do if problem arise, and where to go for resupply.

Counseling on rapport building: is the counseling procedure that emphasize on the pre-counseling interaction of provider with clients from greeting with respect, self-introduction and assure confidentiality & privacy of client.

Exploration counseling: is the main counseling part that the providers explores the knowledge, intension and concern of the client about FP and STI and HIV, intention and concern about FP and give additional explanation and rule out pregnancy.

Informed chose /decision: is decision making process that the choice of family planning the client will interested to use after the provider explain the methods that are suitable/ no effect to client.

Basic instrument /equipment: Is reusable equipment which used for provision of LAFP either implant or IUCD, that constitute items (Sterilizer/Autoclave, gallipot, holding forceps, Mosquito forceps, uterine sound, speculum and tenaculum etc.)

Supplies: Are disposable supplies that were important items for the provision of LAFP and for infection prevention procedure followed which constitute pregnancy test, surgical drapes,sterile gloves, antiseptic solution, lidocane,5 ml syringe with needle and sterile gauze)

Chapter 1: Introduction

1.1. Background

The global population is expected to grow to over 9 billion people in 2050, an increase of more than 50 percent over 2005 levels. This growth will only exacerbate the current health inequities for women and children, put pressure on social services and resources, and contribute significantly to the global burden of disease, environmental degradation, poverty, and conflict.(1-3) In order to reduce the adverse impacts of overpopulation, mitigation measures, such as spreading awareness and education about overpopulation, enacting birth control measures and regulations, and providing universal access to birth control devices and family planning, must be taken. (4) Long-acting reversible contraception, part of the intervention consisting of sub-dermal implants and intrauterine devices (IUDs).(5)

This contraception remains a relatively small and sometimes missing component of national family planning programs in sub-Saharan Africa.(6) But, these methods can enhance family planning programs in meaningful ways if challenges to their availability, access, and acceptability can be overcome.(5, 7, 8)

Access to family planning is a human right, FP is central to gender equality and women's empowerment, and it is a key factor in reducing poverty. (9) Without access to family planning, women are trapped in a vicious cycle that inhibits their full participation in socioeconomic development. The two key social benefits of contraception are women's empowerment and education.(10) Long acting and permanent family planning is a low-cost yet effective way to lower maternal mortality by reducing the number of high-risk births. Every year, half a million women die of problems from pregnancy, childbirth, and unsafe abortion.(11)

The contraceptives provided in 2014 had potential to avert an estimated: 29,000 maternal deaths 10.7 million unintended pregnancies, 3.3 million unsafe abortions and 174,000 child deaths. Most of these deaths could be prevented by family planning. (11) Yet even in 2015, 12% of married or in-union women of reproductive age worldwide want to delay or avoid pregnancy but are not using any method of contraception.(12) Most women with an unmet need for contraceptives live in 69 of the poorest countries on earth. Most this country found in Sub-Sahara

Africa.(9) And nearly 1 in 3 sub-Saharan African women have an unmet need for family planning, the highest proportion (31%) of any region in the world.(13) Ethiopia account for 18.9% of unmet need.(14)

Ethiopia is the second most populous country in Africa next to Nigeria. Projections from the 2007 population and housing census estimate the total population of Ethiopia for the year 2015 and 2020 to be 90 and 100.8 million respectively. The population grows at a rate of 2.6 percent per annually. (15, 16) The average fertility trend in recent years has shown some significant decline from the 2000, 2005, 2011 and 2014 level of 5.5, 5.4, 4.8 births to 4.1births per woman. (15, 17-20)

To minimize the problem related to unwanted population growth our country never sleeps to give hand to face the impact related to it. Instead Ethiopia establishes proactive public policies to address its demographic patterns and trends, such as programs to reduce infant and child mortality, improve education, and increase access to FP. Despite the challenges it faces, Ethiopia may well be on track to capture a demographic dividend.(21)

The Ministry of Health (MOH) is engaged in a range of efforts to improve access and quality of FP services in accelerated manner and scale up long acting and permanent methods in country would vastly improve the health and lives of millions of women, children, and families. The services are provided through government and NGO service outlets, including hospitals, health centers, health posts, and community based distribution and social marketing. (2, 11, 16)

The government of Ethiopian had successfully completed MDG and the 20 years National Health Sector Development Program (HSDP). HSDP has been divided into four series of five-year HSDPs I to IV since 1997. Family planning including long acting methods was as primary component of MDG and HSDP. Currently it is also incorporates with Health Sector Transformation Plan (HSTP), which is the next five-year national health sector strategic plan, which covers (July 2015– June 2020). (11, 22)

Pregnancies that are too early, too close, too many, or too late pose adverse health consequences for the mother, child, and family. In addition to the health benefits, spacing births allows parents to devote more time to each child in the early years, easing pressures on the family's finances and giving parents more time for income generating activities. (11, 23)

In most of part sub-Saharan country client of family planning utilizers they convinced the time spend after taking service for follow up was not acceptable, where women are have a lot of burden. To alleviate this problem long acting family planning are convenient for users. Women who use oral contraceptives must remember to take their pills each day. Likewise, injectable users must have reinjections every one to three months, depending on the type of injectable they are using. Resupply often requires travel to a clinic, and the timing of clinic visits is critical for preventing pregnancies. Long acting and permanent methods require almost no attention on the part of the user after they are initiated, and their effectiveness is not dependent on daily or monthly action.(7)

Women in developing countries would like to delay or stop childbearing but are not using any method of contraception, lack of access to contraceptives, information, and services. This, for many, will cost them their lives. The success of long acting family planning has not been consistent across countries or even within countries. (12, 16)

Globally, female sterilization is the most common method of contraception, used by 29% targeted mothers, followed by 25% were Intra Uterine Contraceptive Device (IUCD) and whereas implant 1% among women aged 15 to 49 years who were married.(24) IUCD is highest in China, as well as the Scandinavian countries, Asian nations and the Near East and North Africa. IUDs remain underutilized, especially in Northern America, Oceania, South Asia and sub-Saharan Africa, in spite of the IUD's many benefits. (25)

Data from demographic and health surveys from four sub-Saharan countries show that the proportion of women currently using long acting and permanent is significantly lower than the proportion using short-acting methods. In many countries of Sub-Saharan region, fewer than 5 percent of women who are using contraception are using an long acting and permanent methods.(7) Implants account for just 7% of all contraceptive methods used in the region and between 2010–11, use of implants rose 17-fold in Ethiopia.(13)

However, based on the 2014 Ethiopian Demographic and Health Survey (mini-EDHS) analysis, the use of modern family planning is low. The most commonly used modern method from married women of childbearing age (15–49) which account 40.1% from thus injectable is dominantly utilized currently by 31 %, 5 % use implants and 1.1% use the IUD. In case of SNNP region 38.6% use any modern FP methods; injectable is dominantly utilized currently by 32.7 %,

3.3 % use implants and 1% use the IUD.(17) According to Hadiya zone performance in the year 2015, among women of childbearing age (15–49) 15% of utilize long acting family planning.(26)

Maintaining an adequate and safe family planning service in general and long acting FP in particular currently is an issue of government of Ethiopia particularly local health planners especially with increase in demand and improve program implementation as a result alignment the size of the population with the economic growth and problems related with pregnancy. These and other main subjects inspire to done this implementation evaluation study.

1.2. Statement of the problem

As a result of uncontrolled population growth in Ethiopia, population density has been increasing rapidly for the last 30-40 years, and it is projected that the population density will be 166 people per square kilometer by 2050.(2)

Even if family planning is a solution for most of the death of mothers, each year there are an estimated 80 million unintended pregnancies, and 42 million of these pregnancies end in abortion. In the least developed countries, 6 out of 10 individuals who do not want to get pregnant, or who want to delay the next pregnancy, are not using any modern method of contraception. (1, 3, 27)

Due to limited accessibility of long acting and permanent FP short acting methods are becoming increasingly available through commercial outlets and community-based distribution, especially in rural areas, where most people live. However, the provision of long acting FP is often confined to urban facilities as a result distance to clinics and fees for services can make it difficult to obtain services. Many potential clients lack information about long acting FP as a result myths and misconceptions are also widespread for these methods. Even in countries where most people know about family planning, only fewer people know of the IUD.(6)

IUDs remain underutilized; especially in sub-Saharan Africa the use of IUD is less common, which account for only two percent of users rely on the IUD.(25) Here in Ethiopia the situation was according to mini-EDHS less than one percent of women utilized. However, knowledge about IUD and implants has increased by 41% and 8 % respectively. Huge inter-country variations in the probability of stopping IUD use were observed. In the country there is higher variation in utilization of LARC in the regions, Addis Ababa which account 16.5%, out of this

7.5% IUD and 8.5% implant. While in Somalia, around 0.2% utilize LARC out of this IUD accounts below 0.09% and 0.2% of it is implant.(17) One of the reasons for low utilization of long acting FP methods is unavailability of the service at the nearby health service outlet. (2, 28)

For those methods that require surgical approaches, insertion, fitting and/or removal by a trained health provider (sterilization, implants, IUDs), appropriately trained personnel in adequately equipped facilities must be available in order for those methods to be offered, and appropriate infection prevention procedures must be followed. Adequate and appropriate equipment and supplies need to be maintained and held in stock.(29)

Study done in sub-Saharan Africa show that to the provide service of LARC commodities, equipment and supplies, and opportunities to train providers are not always available. Even when programs provide long acting and permanent FP, stock outs of the necessary commodities or equipment can be problematic.(6) Study conducted the country Ethiopia show that less than one-fourth (22.4 %) of the respondents were counseled about long acting and permanent FP of contraception by health professionals during their service provision of FP.(30, 31)

Studies done in Africa in Tanzania identified that the key obstacles for service of FP including long acting and permanent methods were; lack of widespread training of providers, coupled with lack of stable provider competency and confidence, lack of consistent supply of methods, equipment, materials and space and Lack of knowledge/interest on the part of potential users and also possible provider bias and circumstances that favor provision of short-acting methods.(5)

Study showed here in Ethiopia southern part of the country Wolaita zone, the respondent women were asked for their approval on LAPMs, more than 20% felt insertion of IUCD interfere with privacy. (42) Study conducted in Jimma Zone, Southwest Ethiopia, shows that all of the health centers had no standard FP guideline.(44) And study in the same area Jimma all SDPs had laboratory unit but because of absence of kit for pregnancy test 4(50%) SDPs have not been performing pregnancy test. (45) Another study conducted in Ethiopia at all Region of District hospitals, health center and health post, shows that some facilities reported experiencing stock-outs in the past six months.

Study conducted in Shashemen Town, Oromiya Region of Ethiopia, less than one-fourth (22.4%) of the respondents were counseled about LAPMs of contraception by health

professionals and more than half 54.2% of the participants treated very well by the health care providers while 45.8% were treated poorly.(31) Study done in Jimma shows that one-third (33.3%) of the consultation sessions, providers used at least one IEC material.(44)

The find of this evaluation during EA that mostly the service provided at health post is only removal of implant this is due to unavailability of trained provider and equipment to provide implanon removal. There were no trained providers and inadequate in number IUCD and Jadelle and Implanon inadequate number to provide health centers were no trained as a result the health facilities were face difficulty to achieve their annual performance/objective of LAFP.

As we know now a days our country Ethiopia, SNNP region, Hadiya zone to Soro district the main concern on improving maternal health with the aid of dynamic shifting from short term FP to long acting. According to Hadiya zone, the study area (Soro district) was lower achievement of annual performance/objectives of long acting family planning in comparison to other districts in the zone. In addition the district is highly populous district twice greater than other districts in the zone. So, doing this evaluation on study area especially made the stakeholders to concentrate on this title of evaluation at study area.

As a result evaluating the program and identifying gap of program implementation is very important to provide information on some component parts the program implementation limitation. Therefore, this study identified the possible problems of long acting FP implementation, to identify implementation status of the program and forward recommendations for further improvement of the program.

1.3. Significance of the evaluation

For effective implementation of long acting family planning the stated problems and the finding shows that hinder to achieve the objective of the program, in addition clients probably not satisfied to the program implementation finally it would be discontinue the methods. In addition this time long acting family planning is the national wide focus area that the government put his effort to shift from short term family planning to long acting and permanent methods. So, doing process evaluation is an input by identify the possible barriers of program implementation and provide systematic information guide on the bases of evaluation dimensions for improve the program in the future. To the best knowledge of the principal evaluator there was no evaluation research conducted in the area of long acting family planning particularly at study area.

In addition doing this assessment on implementation status of long acting FP services in public health facilities of Soro district would give multi-face significance for all program stakeholders be it those involved in program operation, served by the program or those who utilized the evaluation finding. The findings of this evaluation typically would help policy makers to make informed decision based on the finding to redesign the program that needs improvement and help to revise guideline, manuals and trainings.

This evaluation also help for Regional Health Bureau, Hadiya zone health department and Soro district health office and managements by providing information to identify priority areas that need alert on involvement and regular monitoring and strengthening, in addition to this help initiate interventions to be redesigned in order to improve those evaluation findings and to make informed decision. For program planners or program officers, or funders to make their concern in improving program effectiveness and to fill gaps that need special attention for program improvement in resources (skills, equipment and supplies) and to identify the level of support needed and expected to advance the program.

For program implementers particularly health centers staffs and health post HEWs, it would support to take corrective action/initiation on their interaction with client and recording system would be in accordance with national guideline and it would gasp the program by improving that client were not satisfied with the service readiness and factors that hider clients satisfaction on LAFP. Finally this evaluation serve the service utilizers by addressing there intension to which

they need to satisfied with by giving the direction to concerned body to improve the client intension.

It would also serve as new dimension in aspiring and generating new knowledge to the wider audience. Academic wise it would add additional research finding to the academics world and shows possible areas to other interested scholars and prospective graduates.

Therefore, all stakeholders of LAFP program will expected to generate information from this study for the improvement of the program and to achieve the stated objective related to the program and reach to achieve program goal in near future.

Chapter 2: Description of the program

2.1 Overview and development of family planning service in Ethiopia

Family planning services began in the 1966 in Ethiopia with the establishment of the Family Guidance Association of Ethiopia (FGAE), an International Planned Parenthood Federation (IPPF) affiliate. Not until the 1980s did the Federal Ministry of Health (FMOH) add family planning to its maternal and child health program. (2, 11, 16)

FMOH and the NGOs began expanding community-based distribution of family planning services by CRHA, who are volunteers with minimal training on provision of pills and condoms. But this strategy will shift to massive produced HEWs in the country. They were implement 16 health packages, one of which is FP; provide short-acting methods for long run and training for HEWs to provide the implant (Implanon) began in the 4 regions of the country including SNNPR in 2009 before being scaled up nationally in 2010.(14) HEWs counsel clients for FP, including insertion of Implanon service and the health centers are responsible for removing the implants. This is the first non-professional cadre to insert implants in Africa.(11)

The Ministry of Health (MOH) is engaged in a range of efforts to improve access and quality of FP services in accelerated manner and scale up long acting FP in country. The services are provided through government and NGO service outlets, including hospitals, health centers, health posts, and community based distribution and social marketing. (2, 11, 16)

Taking into account the early success in Implanon scaling-up initiative and the huge demand for long acting family planning methods in Ethiopia, the Ministry of Health launched and implemented an IUCD scale-up initiative project in 2011. The government made a massive investment to expand the health infrastructure, especially building new primary hospitals, health centers and health posts to reach health services to including long acting FP of family planning accessible to all of the community.(11, 14)

Types of family planning services provided at different service delivery points: Household/ Health post services short acting FP and the only long acting FP service available is single rod implants (Implanon), as well as counseling following referral. And at health center and primary hospital service includes both short term and all long acting FP.(2, 28) The provision of FP services is dependent upon the integration of services throughout the health care system that enables maximum utilization of health care services in one visit. (21, 23) (28)

2.2. Overview of long acting family planning

Long-acting reversible contraception (LARC), consisting of sub-dermal implants and intrauterine devices (IUDs). When compared with methods such as implants and IUDs injectable are not truly 'long-acting'.(5, 8)

Implants are hormonal contraceptive method, are inserted under the skin of a woman's upper arm and provide continuous, highly effective pregnancy continuous protection for 3 to 7 years, depending on the type of implant and number of rods inserted. There are four types of contraceptive implants discovered until today. These are Norplant, Jadelle, Implanon and Sino-implant, according to their sequence of discovery.(1, 2, 32)

Norplant and Jadelle is a progestin-only contraceptive implant that consists of six and two rods and their protection from unwanted pregnancy 5 to 7 years and 5 years respectively. Norplant was the first implant and its manufacture was phased out in 2004 due to its decreases effectiveness. Sino-implant is another implant of two rods it was introduced after Implanon and is available in Ethiopia, but it has been approved by the Ministry of Health for use recently. And Implanon is a single-rod contraceptive implant, which gives effective protection for three years.(2, 8, 32, 33)

Intrauterine contraceptive devices (IUDs), it is also known as IUCD are small, flexible plastic devices that are inserted into the woman's uterus. Depending on the type, IUDs can provide protection for 5 to 12 years, there are two popular brands of IUD available globally. The ParaGard IUD contains copper (TCu-380A) most commonly used and is effective for 12 years and the Levonorgestrel-releasing IUDs (Mirena, Skyla, and Liletta) is effective for at least 5 years. If IUCD can be used within five days of unprotected sexual intercourse used as an emergency contraceptive. The copper-bearing IUCD brand TCu-380A is widely available in Ethiopia.(1, 2, 25, 33, 34)

2.3. Stakeholders Analysis and Engagement

A stakeholder analysis provides a means to identify the relevant stakeholders and assess their views and support for the proposed evaluation. A stakeholder can be defined as any individuals, groups of people, institutions or organizations that may have a significant interest in the success or failure of a potential project around the issue of concern. These may be affected either positively or negatively by a program. In case of formative evaluation the interaction with stakeholders are may be highly collaborative, who take primary responsibility for planning, conducting, and using the evaluation.(35-37)

Stakeholders must be engaged in the inquiry to ensure that their perspectives are understood. When stakeholders are not engaged, an evaluation might not address important elements of a program's objectives, operations, and outcomes. Therefore, evaluation findings might be ignored, criticized, or resisted because the evaluation did not address the stakeholders' concerns or values.(38)

Identifying and engaging the following three principal groups of stakeholders are critical(37, 38):

Those Involved in Program Operations: Persons or organizations involved in program operations have a stake in how evaluation activities are conducted because the program might be altered as a result of what is learned. In case of Soro district, zonal health department technical staffs and district health offices technical staffs, health centers and health post service providers, program managers, funding officials, and partners work together on a program like Engender Health, IFHP, AHA, FHI-360 and Mari stops are those who identified stakeholders of program operations on long acting family planning service.

Those Served or Affected by the Program: Persons or organizations affected by the program, either directly (e.g., by receiving services) or indirectly (e.g., by benefitting from enhanced community assets), should be identified and engaged in the evaluation to the extent possible. In the circumstance of this evaluation general community, women in reproductive age group, Women's and Child affairs office and religious leaders were those identified stakeholders served or affected by the program.

Primary users of the Evaluation: Primary users of the evaluation are the specific persons who are in a position to do or decide something regarding the program. In practice, primary users will be a subset of all stakeholders identified. Regional health Bureau and Hadiya zone health department are the identified program primary users of the evaluation.

There was different communication strategies used with different stakeholders. By having formal letter from Hadiya zone health department, all stakeholders assumed to use the evaluation or can affect the use of evaluation finding are addressed by Evaluability Assessment. Some of the stakeholders were not found during EA due to different reasons like, participating on different meetings and trainings and for those stakeholders**,** e-mail and telephone communication was found to be a convenient option of communication if their representatives are not assumed to be decision makers for that organization.

Though, all stakeholders are equally important for the program, those who will directly involve in the evaluation process and their level was made based on their contact with the program, their scope and level of stakeholder involvement will vary for the evaluation. (38)

It was clearly stated in stakeholder analysis matrix table level of importance were based on decision making on the program implementation. Those who were a power to decide on the program implementation are leveled as High importance and others are leveled with respect to their decision making on the program.

Table 1: Stakeholder Analysis for long acting FP program in public health facility of Soro district, Hadiya Zone, Southern Ethiopia, 2016

Stakeholder	Role in the program	Interest or perspective on evaluation	Role in the Evaluation	Communication strategy	Level of importance
Regional Health Bureau (RHB)	- Budget allocation - Technical support (training, supportive supervision) - plan, report, supervision, review meeting, evaluation	❄ To know the level of implementation of the program ❄ Utilizing the results for decision making ❄ To identify the level and type of support the program need	۞ Interpreting findings ۞ For dissemination of the finding	E-mail Telephone	High
Hadiya zone health department (program managers, general staff)	- Budget allocation - Recruitment of human resource - Administrative service - Technical support (training, supportive) - Monitoring and evaluation	❄ Utilizing the results for decision making ❄ To figure out the gaps in resource distribution, training needs assessment, client satisfaction level ❄ To identify the level and type of support the program need	۞ Describing program activities and outcomes ۞ information provision about the program ۞ Selecting evaluation questions and methods ۞ Serving as sources of data ۞ Establish the criteria ۞ Interpreting findings ۞ Dissemination of the result	Discussion meeting Formal letter Telephone	High
District health offices (program managers, general staff)	- Administrative service - Technical support - Monitoring and evaluation	❄Utilizing the results for decision making & program improvement ❄To figure out the gaps in resource distribution,	۞ Describing program activities and outcomes ۞ information provision about the program ۞ Selecting evaluation questions and methods	Formal letter Telephone	High

		training needs assessment, client satisfaction level ❄To know the level of implementation	۞ Serving as sources of data ۞ Establish the criteria ۞ Interpreting findings ۞ Dissemination of the result		
Health centers and Health post (program managers, service providers, general staff and HEWs)	- Program implementers - Service provision according to guideline - Administrative service &Technical support - Availing essential supply and equipment - Recording & reporting accordingly	❄ Utilizing the results for program management and to improve the service ❄ Identify areas which need improvement in three of the dimensions of this evaluation ❄ To identify the level and type of support the program need	۞ Describing program activities, context, priory ۞ Selecting evaluation questions and methods ۞ Serving as sources of data during the evaluation ۞ Interpreting findings ۞ Dissemination of the result	Discussion meeting Formal letter Telephone	Medium
NGOs (IFHP, AHA, FHI 360, OSSA, MSI & Engender Health)	• Technical support (training, supervision and review meeting) • Provision of equipment & supplies	❄ To focus their attention on to fill the gap ❄ Identify priority program planning and funding	۞ Interpreting findings and disseminating information ۞ Utilizing the results for financial & technical	Discussion meeting Telephone & Formal letter	Medium
Women and Children affair office	-Supportive organization -Sustain gender equality -Empower women HHs participation	❄ Utilizing the results for improve their support	❄ Serving as a source of information	Formal letter	Low
Primary program beneficiaries	- Beneficiary of the program - Utilization of service - Involvement in the program - Approval to the service provided	❄ Enhance knowledge on service they received ❄ Utilizing the results & findings for involvement in the program	۞ Serving as sources of data during the evaluation	Discussion meeting	Low

2.4. Program goal and objectives

Program goal:

To improve the health of families and individuals particularly contribute to reduce maternal and child morbidity and mortality.

General objectives:

- To Increase Contraceptive Prevalence Rate (CPR) from 39% to 55% by end of 2020.
- To Reduce Total Fertility Rate (TFR) from 4.4 to 3.1 by end of 2020.
- To reduce unmet need for family planning from 24% to 10% by end of 2020. (22, 26)

Specific Objectives:

- To increase contraceptive acceptance rate (CAR) from 52% to 80% by end of 2016.
- To increase the proportion of long acting users from 12% to 50% by the end of 2016.
- To increase the proportion of women using implant from 8% to 25% by 2016.
- To increase the proportion of IUCD users from 4% to 15% of the total contraceptive users by the end of 2016.
- To avail all necessary long acting FP resources consistently to FP centers by the end 2016.
- To achieve regular, timely and complete recording and reporting system 100% by the end of 2016.

2.5. Major strategies

The government of Ethiopia has advanced family planning as one of the main strategies to improve maternal and child health and bring about overall development in the country. Accordingly, a number of strategies were implemented to increase access to and demand for quality family planning service through expansion of contraceptive method mix, emphasizing in the provision of long acting FP at lower level SDP. The MOH has been aggressively expanding IUCD and Implanon scale up national efforts has incorporated both traditional and innovative approaches to address key barriers;

Provide people with accurate information: Increasing awareness of long acting methods and addressing common myths and misconceptions about the methods can improve acceptability and create demand for services. Programs have disseminated accurate information about long acting FP in various ways.

Expand services in rural areas: Expanded availability of long acting and permanent methods is essential for improving access to a range of family planning methods and services. Several efforts have been made to increase rural women's access to long acting and permanent by addressing restricted mobility, inadequate information about family planning, and lack of trained personnel.

Facilities based family planning services by level of care: the provision of FP services is dependent upon the integration of services throughout the health care system starting from the community level to specialized referral hospitals. These are due to the type of services provided and the type of providers staffing at facilities.

Outreach and mobile outreach: outreach is a service when a health center staffs FP service provision program at the health posts or kebele under its catchment. Instead of mobile outreach the health center staffs are accompanied by staff from hospitals to provide long acting FP at health post or health center level. One of the reasons for low utilization of long acting and permanent method is difficult geographic access, or unavailability of the service at the nearby SDP. Hence, the outreach or mobile outreach program is meant to cover those limiting factor.

Expand the role of NGOs/private sectors in FP Program: FMOH recognizes the important role and contribution of NGO expanding their role can enhance consumer choice by increasing the number of available sources of long acting FP. Non-Governmental Organizations will partner with shall continue to take part in FP programs in render FP services & support the program.

2.6. Program component

A process evaluation generally measures resources, activities, and outputs as they pertain to the implementation of the initiative. We can get information on program component from the description of the program and from a well- developed and complete logic model. (39)

This evaluation was emphasized on the most fundamental component part the program (program implementation theory) that was input, activity and output. And only one proximal (immediate) outcome of the program that is to measure the satisfaction level of long acting service users.

2.6.1. Program Inputs

Assessing the resources in answering the question, what human, financial and material resources were provided and used by program. The components that were assessed include: Funding levels and distribution of financing, resources available and utilized for delivering the initiative, number and qualifications of staff and others implementing the program and quality of the curriculum used for training those delivering the program and for program participants.(39)

The identified input for long acting FP program were trained human resources on long acting, financial resource, infrastructures (health facilities), logistics and supplies, guideline and manuals, IEC/BCC materials and reporting & recording formats.

2.6.2. Program Activities

Assessing the processes (activity) in answering the questions, Was the initiative implemented as described in the plan? And how well was the program implemented. The components that were assessed include: implementation of components of the initiative, intensity and reach of activities, participation of target population, staffing for program activities & training. (39)

The major activities that are process to attain the output of the programs are organize training, provision of health education, FP counseling, provision of service & referral services, integration of service with other program, availing & maintain logistics and supplies, recording & reporting and supportive supervision and performance monitoring.

2.6.3. Program Outputs

The outputs of the program are the products of the program activities, so to assess the products we have to know what the activities (processes) was intended to produce. Components for assessing the outputs of a program were include: Materials developed, Services provided, People trained and Plans put into operation. (39)

2.6.4. Program Outcome and Impact

Outcome emphasis on the initiative make a difference to those who were exposed to it? They assess the expected effects as well as the unexpected effects of the program. Outcomes are

carried out after the program is established and the activities (processes) are expected to have had an effect that is measurable. Those outcomes are categorized as immediate and long acting. Mostly long acting outcomes are called Impact.(39)

The immediate outcomes of long acting FP program is improved knowledge, health seeking behavior and client satisfaction on the services, advancement in utilization and Adherence of long acting FP and improve decision making & service quality of long acting family planning that the health facility and health care providers are delivering for them. And the proximal outcome or Impact of the program are decline of unmet need and reduction of fertility rate, thus contribute to reduction of maternal and child morbidity and mortality which lead to increase productivity.

2.7.Program logic model

A logic model describes the sequence of events for bringing about change by synthesizing the main program elements into a picture of how the program is supposed to work. One of the virtues of a logic model is its ability to summarize the program's overall mechanism of change by linking processes to eventual effects. Elements that are connected within a logic model might vary but generally include inputs (resources), activities, outputs, and results ranging from immediate to intermediate to long-term effects. Creating a logic model allows stakeholders to clarify the program's strategies; therefore, the logic model improves and focuses program direction.(38)

During Evaluability Assessment in collaboration with stakeholders the program logic model was developed after listing out the implicitly program theory of long acting family planning program.

Problem statement: Ethiopia 2nd populous country in Africa and in year 2014 nationally unmet need of 18.9%. SNNP long acting utilizers were below national that was IUD 0.1%; implant 3.3% & Hadiya zone achieve 15% long acting FP in 2015 while Soro district 11%.[17, 28]

Goal: To improve the health of families and individuals particularly contribute to reduce maternal and child morbidity and mortality.

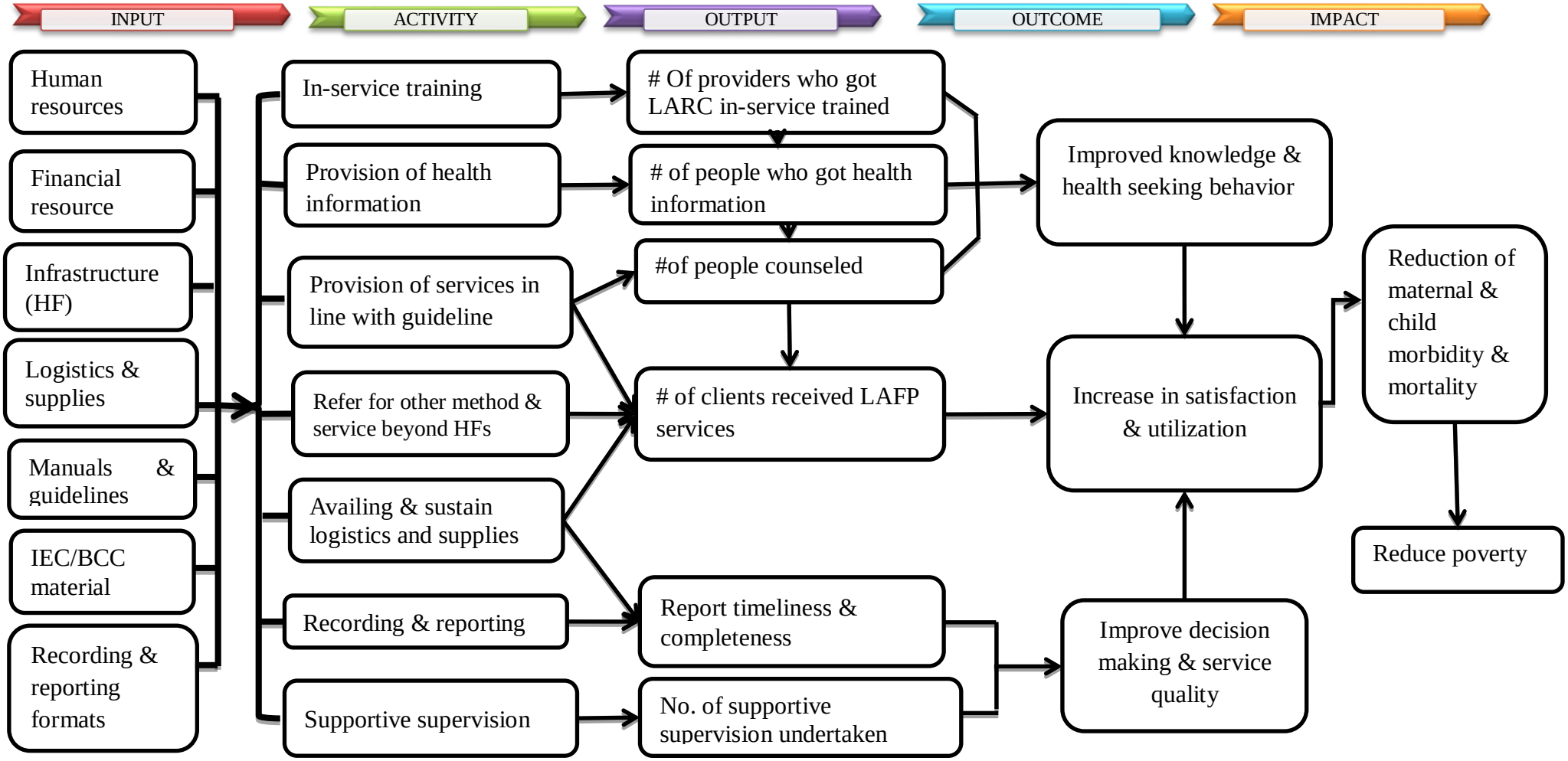

Figure 1: Logic model of long acting FP program in public health facility of Soro district, Hadiya Zone, Southern Ethiopia, 2016.

2.8. Stage of program development

The modern family planning service in Ethiopia started as the FGAE, established in 1966. After gating legal status 1975 the first family planning clinic was opened in the same year in Addis Ababa at a single-room clinic run by one nurse. The Ministry of Health (MOH) integrated FP with a national MCH program in the early 1980s in public facilities. And since 1975 family planning services have been provided through a variety of mechanisms in the country mainly from public hospitals to community-based distribution systems, to social marketing, and outreach services.(2, 28)

In 1996, the first 'Guidelines for FP services in Ethiopia' was released and was updated in 2011. The launching of HEP, in 2003, that advent of HEWs was a turning point for expand FP services for under-served rural and remote communities. After a long run training for HEWs to provide the implant Implanon began in 4 regions of the country including SNNPR in 2009 and scaled up nationally in 2010. This is the first non-professional cadre to insert implants in Africa.(11, 16, 28)

Taking into account the early success in Implanon Scaling-up initiative and the huge demand for long acting family planning methods in Ethiopia, the MOH launched and implemented an IUCD scale-up initiative project in 2011. The Ministry of Health (MOH) is engaged in a range of efforts to improve access and quality of FP services in accelerated manner and scale up long acting methods in country. At present almost all public hospitals, health centers, and health posts in the country provide family planning services. (11, 14)

During Evaluablity Assessment the program stage of development were identified; all long acting FP was identified as matured programs to be evaluated but Sino II implant was immature. This due to Sino II implant was come to implementation recently at zonal level and Soro district, there is no data /report and document/ found in most of health facilities that show the implementation of the program.

2.9.Context of long acting family planning service in Soro district

To make family planning more affordable by client all public health facilities of Soro district were providing a service that the clients are not asked to pay for contraceptives. They can get any service free of charge at public health institutions.

Family planning activities are being incorporated into other health programs such as HIV/AIDS and pre- and post-natal care. Financial constraints remain a challenge in continuing to support the program, as does expanding the method mix with greater method choice.

Soro district with the collaboration with different NGOs, all categories of public health facilities including health post provide family planning services including long acting FP by integrating with other program. All public health centers provide long acting family planning service includes health education, counseling, referrals and supervision. While rural health extension workers provide the only long acting FP insertion implant (Implanon) and the health centers are responsible for removal. Whereas UHEWs were refer clients for their catchment /town health center and provide the service at health center level. Currently, the service has been provided to rural communities at household level through the Health Extension Program (HEP) Implanon insertion and female Health Development Army (HDA) that mobilize and provide health information to the community at large.

Chapter 3: Literature Review

Determinant of LARC services

Yet several strong barriers to long acting and permanent FP use persist in sub-Saharan Africa.(1) Clients have a right to services that are affordable, are available at convenient times and places, are fully accessible with no physical barriers, and have no inappropriate eligibility requirements or social barriers, including discrimination based on sex, age, marital status, fertility, nationality or ethnicity, social class, religion, or sexual orientation.(28)

The low current use and low ever use of LARC in Sub-Saharan African suggest that women do not have sufficient access to and/or knowledge about the methods.[1] In most developing countries like Ethiopia, providing effective family planning services which address the needs of the community is essential. Therefore, service delivery strategies need to be design to reach populations in different locations, such as urban areas, rural towns, villages and remote areas.(2)

Limited access to LARC is a problem. Short acting methods are becoming increasingly available through commercial outlets and community-based distribution, especially in rural areas, where most people live. However, the provision of LAPMs is often confined to urban facilities. Distance to clinics and fees for services can make it difficult to obtain services.(6)

Ensuring access to information and services of modern contraceptives to women would reduce maternal deaths by 25 percent, newborn deaths by 18 percent and unintended pregnancies by 73 percent. (40) Knowledge of family planning is a must to obtaining access to and using a suitable contraceptive method in a timely and effective manner. Study conducted in Debre Markos on intension to use LAPMs shows that about three-quarters 74.7% of the women reported that implants act for a long period and 30.0% did not know the advantage of the methods. Acting for a long period was also reported for IUCD by 44.4% and 45.0% did not know its advantage. (17, 41)

Study conducted in Wolaita Zone, Southrn Ethiopia the respondent women were asked for their approval on LAPMs, 30.4% of them agreed that it is not good to use LAPMs. More than 20% felt insertion of IUCD interfere with privacy. About 16.8% of women admitted that using IUCD restricts normal daily activities. And also 67.2% of women had myths and misconception on LAPMs.(42)

A Qualitative Study conducted in Adigrat Town, Tigray, Northern Ethiopia, on knowledge LAPMs: Finding from FGD indicate that some women had expressed their concern on IUD on the need of vaginal examination, discomfort during sex, side effects, and lack of protection against sexual transmitted infection.(43)

Study in Tanzania identified the key barriers for service of FP including LAPMs were; (1) lack of widespread training of providers, coupled with lack of enduring provider competency and confidence; (2) lack of consistent supply of methods, equipment, materials and space; (3) lack of knowledge/interest on the part of potential users; (4) possible provider bias and circumstances that favor provision of short-acting methods.(5)

Availability of Long acting FP service and components

In most developing countries like Ethiopia, family planning programs in general and long acting FP in particular, is limited and cannot be accessed by everyone. One of the reasons for low utilization of long acting family planning methods is unavailability of the service at the nearby health service outlet. (2, 28)

For those methods that require surgical approaches, insertion, fitting and/or removal by a trained health provider, appropriately trained personnel in adequately equipped facilities must be available in order for those methods to be offered, and appropriate infection prevention procedures must be followed. Adequate and appropriate equipment and supplies need to be maintained and held in stock.(29)

Commodities, equipment and supplies, and opportunities to train providers are not always available. Even when programs provide Long acting FP, stock outs of the necessary commodities or equipment can be problematic.(6) The supplies of the family planning materials may not be regular and reliable, in most health facilities the space or room for the provision of family planning is integrated with other reproductive health programs. This can make it really difficult for you to find a place where privacy and confidentiality can be maintained.(2)

Study conducted in Jimma Zone, Southwest Ethiopia, on quality of family planning shows that all of the health centers had no standard FP guideline. And none of the health centers had bill-board or displayed posters about FP in and around the facility campuses. Concerning the

availability of basic materials (equipment and commodities), each health center had Sterilizer /Autoclave, Blood pressure apparatus, Weight scale, Flash light, Uterine sound, Speculum, Scissors, Teneculum, Antiseptic solutions, Disposable gloves, Examination table, Thermometer, Needle and Syringe, Sterile gloves, Pregnancy test, different contraceptive methods and Minor surgery set. (44)

Another study conducted in the same area (Jimma) show that only 3 SDPs from 8 SDPs had a copy of MOH guideline of FP service in Ethiopia. Tubal ligation, vasectomy, implant (norplant), spermicide, diaphragm and cervical cap were available only in Jimma branch FGA clinic from 8 SDPs. All SDPs had laboratory unit but because of absence of kit for pregnancy test, 4(50%) SDPs have not been performing pregnancy test. All SDPs didn't receive a supervisory visit on FP services in the past 3 months prior to data collection time.(45)

Another study conducted in Ethiopia at all Region of District hospitals, health center and health post, shows that some facilities reported experiencing stock-outs in the past six months and service delivery environment (medical examination areas, cleanliness, lighting, and privacy) and infrastructure were good.(46)

Compliance of long acting FP

Study conducted in Shashemen Town, Oromiya Region of Ethiopia, less than one-fourth (22.4%) of the respondents were counseled about LAPMs of contraception by health professionals.(30, 31) Another study conducted in Debre-Tabore town, Northwest Ethiopia on long acting contraceptive, the results show that during provision of the services, 94.3% clients were treated with respect, adequate privacy and dignity by the care providers. More than half 54.2% of the participants treated very well by the health care providers while 45.8% were treated poorly.(31)

Study conducted in in Jimma Zone, Southwest Ethiopia on quality of Family planning, show that the mean+SD waiting time of clients before getting service was 16.4+18.1 minutes with range of 3 -180 minutes. In general, the waiting time was acceptable (within 30 minute) to 92.4% of the clients. In 65.3% of the cases, the provider greeted the clients in beginning of consultations. One-third (33.3%) of the consultation sessions, providers used at least one IEC material. From two of

IUCD insertion procedures observed, the providers used uterine sound and speculum, followed sterile procedure and emotional support was given.(44)

Study conducted in Debre Markos, 52.6% of respondents had discussion about LAPMs at least once with the health care providers and the most commonly discussed methods were Implanon 45.5% whereas male sterilization 3.1% were the least mentioned.(47) Study conducted in Arbaminch Hospital, Southern Ethiopia shows that 74.3% of the respondent discussed about problems related with FP method. Out of the total respondents 51% of them got good approach from the health providers. Health providers tried to understand the problem for 68.85% of the respondent. As they responded 79.86% of them get appropriate condition to ask question. And 72.22% of respondents get enough information and the remaining 16.05% of them get little information.(48)

A Qualitative Study conducted in Adigrat Town, Tigray, Northern Ethiopia family planning providers in the in-depth interview indicated that the counseling service they were providing was not inclusive of all modern contraceptives.(43)

Client perspectives and satisfaction on long acting family planning services

One principal determinant of uptake and continued utilization of family planning services is overall client satisfaction with those services. Studies of contraceptive discontinuation rates, for example, have indicated that - with the exception of the desire to become pregnant - the principal reason for discontinuation is dissatisfaction with the quality of services.(49)

Another study conducted in Jimma Zone, majority of the respondents were satisfied (agree and strongly agreed) with ease of getting clinic site (89%), waiting time (93.4%), clinic working hour conveniences 97%, cleanliness of clinic area 89%, information sufficiency 84.7%, maintaining privacy (93%), sufficiency of consultation time (94.4%) and friendliness and respectfulness of the staff treatment (95.3%).(44)

Study conducted in the same area (Jimma zone) that shows that majority of clients, 52.1%, were very satisfied with provider's behavior, 42.0% were somewhat satisfied, 5.0% were neutral but the rest 0.8% were very dissatisfied; with maintenance of privacy, 55.6% were very satisfied,

35% were somewhat satisfied, 39(6.1%) were neutral, 2.8% were somewhat dissatisfied and the rest 0.5% were very dissatisfied.(45)

Study conducted in Hossana town, southern Ethiopia, on client satisfaction on FP and determinants, shows that majority 88.3% of participant were satisfied on cleanness of health facility, fewer participants were satisfied with technical aspect of health provider (70%).(50)

Study conducted in four African country, waiting times were nearly always considerably longer at public facilities. In both Tanzania and Kenya, FP clients waited over 40 minutes longer on average at public sector health centers, roughly 40% of clients reported problems with waiting times at public clinics in Kenya. The highest levels of dissatisfaction were with the cleanliness of public health centers, for which 12% of respondents reported a problem.(49)

Chapter 4: Evaluation Questions and Objectives

Due to limited time and resources, it is not feasible to evaluate every element or path on each component in the logic model of a program. Therefore, selecting questions to be evaluated found to be important for addressing stakeholders' questions. During EA, different participant stakeholders (MCH coordinator of WoHO, HC heads and service providers (9HEWS and 9HWs) and OSSA field officer, IFHP Hadiya cluster coordinator) were exposed opinions regarding the evaluation questions. Certain stakeholders have wanted to study how programs operate together with effect of change of interventions (program) within a community. Other stakeholders have had questions concerning the performance of a single program. Still others wanted to concentrate on specific subcomponents or processes of a project. After a clear discussions negotiation and prioritization of questions, we reached to consciences on three process evaluation question.

4.1. Evaluation Questions

- Do health facilities of Soro district have all necessary resources to carry out long acting family planning service? If yes how? If not why?
- Do long acting family planning service provided according to national guideline? If yes how? If not why?
- Are clients satisfied by service readiness of public health facilities of Soro district to provide long acting family planning? If yes how? If not why?

4.2. Evaluation Objectives

4.2.1. General Objective

To assess the implementation level of long acting family planning program in public health facility of Soro district, Hadiya Zone, Southern Ethiopia, 2016.

4.2.2. Specific Objective

- To assess the availability of resources for long acting family planning services.
- To assess the compliance of long acting FP service provided in line with national guideline.
- To describe the levels of clients' satisfaction on service accommodation of public health facilities to provide long acting family planning services.
- To identify factors that affect client satisfaction with long acting family planning service provided in public health facilities of Soro district

Chapter 5: Evaluation Method

5.1. Study area and Evaluation period

The study was conducted in Soro district, one of the districts in the Southern Nations, Nationalities, and Peoples' Region of Ethiopia. Part of the Hadiya Zone, which is one of the 10 districts in the zone, and located 267 kilometer from Addis Ababa, the capital city of Ethiopia, and 226 kilometer from regional city, Hawassa and also 32 kilometer away from zonal city of Hadiya zone, Hossana. The district is bordered on the South by the Kembata Tembaro Zone, on the Southwest by the Dawro Zone, on the west by the Omo River which separates it from the Oromia Region, on the north by Gombora district, on the northeast by Limo district, and on the southeast by Duna district. The administrative center of this district is Gimbichu; other towns in district include Jajura and 49 kebeles includes 47 rural kebeles and 2 urban kebeles.(26)

According to the national census of 2007, for year 2016 the projected total population of the district is **235,894** from which Male 116,697 (49.47%), Female 119,287 (50.53%), from this reproductive age group of the population is **46,707** (19.8%).The total household of the district is estimated to be 11,559. (26)

In the district there are 10 health centers, out of this one is administered by NGO (Catholic health center) and 47 health posts. There are different private health service delivery institutions from them 1 medium clinic, 13 primary clinics, 6 drug stores. Except NGOs health centers (Catholic health centers) all health facilities rendering family planning service including long acting. (26)

Evaluability Assessment was conducted from December 16-25, 2015 and the data collection of the study was conducted from March 7 up to April 5, 2016 in public health facility of Soro district.

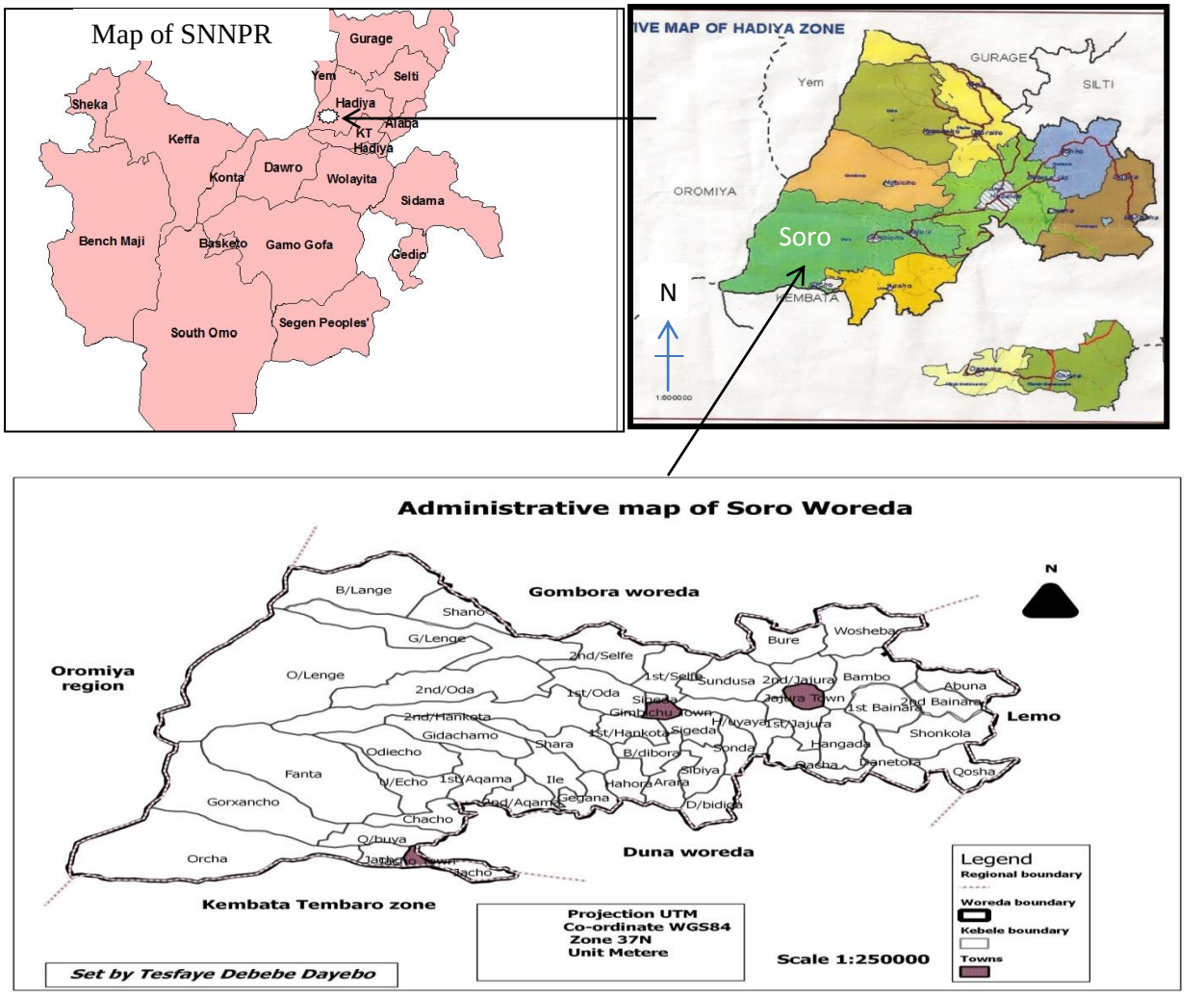

Figure 2: Administrative map of Soro district Hadiya zone, Southern Ethiopia. (the study area)

5.2. Evaluation approach

Formative evaluation approach was employed to assess the implementation of long acting family planning program in Soro district, Hadiya zone. Formative evaluation is used to provide information that will guide program improvement, because its purpose is to help form or shape the program to perform better.(36) Generating ongoing information that ensures program implementation is successful, continuously improving program operations, supplying rapid feedback about operations and outcomes that guides program evolution in an increasingly dynamic and turbulent environment and demonstrating the value of implemented programs to funders, donors, and the public.(51)

5.3. Evaluation Design

A facility based single case study design with quantitative and qualitative data collection methods was employed in this evaluation. The qualitative data was supplementing the quantitative data. Case study design enables to answer "how" and "why" type questions, while taking into consideration how a phenomenon is influenced by the context within which it is situated. It enables to gather data from a variety of sources and to converge the data to illuminate the case.(52)

5.4. Focus and Dimensions of the Evaluation

This evaluation mainly focused on the process of long acting family planning implementation: in addition short term outcome was covered using accommodation sub-dimension. Availability of required resources to implement the service, compliance of service provided in accordance with guideline standard was the main focuses of this evaluation. In addition short term outcome of long acting family planning service readiness was assessed from client perspective using outcome indicators of satisfaction on accommodation.

Availability: refers to the physical access or reachability of services that meet a minimum standard. These specification in terms of the elements of service delivery such as basic equipment, drugs and commodities, health workforce (presence and training), and guidelines for treatment.(53) Like any other programs, long acting FP service provision also encounters a number of challenges with regard to implementation. Here after, this evaluation study was assess availability of the required resources like trained provider, equipment and supplies, availability of contraceptives and methods, availability of standard recording and reporting materials, IEC materials and FP implementation guidelines etc.

Compliance: is the degree to which long acting FP service being rendered in Soro district public health facilities are aligned /comply with the national guideline. Therefore, in this evaluation study to assessment compliance of long acting FP, *the national FP guideline Ethiopia and WHO a hand book for provider* will be used. This is because for national FP guideline, WHO a hand book for providers was the main source of it and national guideline not incorporate method specific information. The national guideline relied on the belief that the guideline that currently Ethiopia uses for FP program implementation also.

Accommodation: - this dimension is assessed through clients' perspective /client view/ that the state of being satisfied about the manner in which the health facility organized resources including infrastructures to accept client. It will enable the program to examine how the client views the services organization so that any problems can be addressed. To do these clients were asked different questions concerning on satisfaction on the program issues in general.

5.5. Indicators and variables

5.5.1. Indicators

During Evaluability Assessment a lot of indicators were listed and based on their relevance to the sub-dimensions /relevance matrix/criteria, indicators were selected and prioritized. For this evaluation only very relevant and relevant indicators was selected and the following list of indicators were identified and agreed to be used during this process evaluation of long acting family planning program at public health facilities of Soro district through active participation of stakeholders. The indicators were adapted from the objective and strategies of national family planning guideline and other relevant readings.

The evaluation indicators was process indicators within the total of 32 indicators; availability, compliance and satisfaction (Accommodation) indictors 9, 12 and 11 indicators respectively were identified and agreed for measuring the implementation of the program and for addressing criteria that was used to judge the program of long acting family planning program at public health facilities of Soro district.

List of indicators

Availability Indicators

- Number of service providers who receive in-service training on long acting methods
- Proportion of HFs having basic instrument /equipment for provide long acting FP
- Proportion of HFs having all long acting FP contraceptives in accordance to service provided
- Proportion of HFs having supplies for provide long acting FP
- Proportion of HFs having at least one FP guideline
- Proportion of HFs having separate FP room
- Proportion of HFs having IEC material for each service of long acting FP provided by HF

- Proportion of HFs experience stock out of long acting contraceptive for more than 30 days in the last consecutive 6 months
- Proportion of HFs having all recording & reporting formats (logbook, tall sheet, report sheet)

Compliance indicators

- Proportion of client counseled on rapport building according to national guideline
- Proportion of client counseled on exploration according to national guideline
- Proportion of clients made informed chose /decision
- Proportion of clients counseled on long acting FP by aid of at least one IEC materials
- Proportion of client got basic information on the method accepted (possibility of switching, side effects…)
- Proportion of client informed about the procedure (insertion & removal) of the selected method
- Proportion of LAFP service provision procedures followed infection prevention procedure according to national guideline
- Proportion of clients discuss on follow-up and revisits
- Proportion of client got instruction on wound care or check for IUCD in place(post insertion counseling)
- Proportion of HFs that follow consistence of recording and reporting the last 3 months performance
- Proportion of health facilities refer clients to next level using standard referral form
- Proportion of health facilities having follow up mechanism for tracing clients of LAFP

Accommodation (satisfaction) indicators

- Percent of client satisfied by the approach of service provider
- Percentage of client perceive the availability of sufficient LARC methods
- Percentage of client perceive the distance between home and service delivery point convenient
- Percentage of client perceive that the counseling time is convenient
- Percentage of client perceive waiting time at service delivery point is short
- Percentage of client satisfied by privacy during counseling

- Percentage of client satisfied by waiting area
- Percentage of client satisfied on HFs having functional latrine & piped water
- Percentage of client satisfied by cleanliness of the facility
- Percentage of client satisfied with number of days LAFP services is available
- Percentage of client satisfied by working hours of the facility

5.5.2. Variables of the study

This evaluation has the objective of assessing the satisfaction of clients on service provided by health facilities of Soro district. Accordingly the following were the dependent and independent variables selected for this study and checked the association if any.

Dependent variables:

- Client satisfaction

Independent variables:

- Visit of the respondent
- Distance
- Tendency to have a child
- Plan when to have child
- Consultation understandability
- Socio-demographic variables (age, education, marital status, occupation, Religion, income, family size and place of residence)

5.6. Population and sampling

5.6.1. Source population

- Long acting family planning users at public health facilities Soro district were source population for exit interview and observation,
- Public HFs long acting FP providers were source population for key informant interview.

5.6.2. Study population

- Those long acting family planning users visited the selected health facilities during the study period were source for exit interview and observation

- Selected HFs family planning provider were study population for key informant interview.

5.6.3. Study unit and sampling unit

- Client of long acting family planning users visited the selected health facilities at study period that fulfill the inclusion and exclusion criteria of the study were study units for exit interview and observation.
- Selected HFs family planning experienced provider and counselors were study units for key informant interview
- Selected health facilities FP registration logbook, service delivery tally sheet, and contraceptive dispensary tally sheet of the previous 3 months and monthly report of the last 3 months and plan performance for the previous 6 months were study units of document review.
- Public health facilities in Soro district, long acting FP clients, service providers, registers (logbook, service delivery tally sheets, dispensary tally sheet), documents (report, plan performance, minute) were sapling unit.

5.6.4. Sample size determination

5.6.4.1. Sample size for quantitative data

The sample size for this study was determined using single population proportion formula by taking p value 50% due to the fact that there is no related study conducted in client satisfaction of long acting FP. Other assumptions made during the sample size calculation with 5% marginal error (d) and confidence interval of 95%($z\ \alpha/2 = 1.96$). Based on these assumptions, the sample size was calculated as follows:

Where z alpha =level of significance

P=50%

d=margin of error 5%

$n= Z^2p(1-p)/d^2$

$n=1.96^2 *0.5^2/0.05^2$

n= 384

Final sample size becomes 384 for this study.

And for direct observation of compliance with national guideline to collect information regarding counseling, examination, procedure of the method followed and documentation and registration. Accordingly 10% of sample size of the exit interview, (i.e. 39) observation session were conducted and distributed to each health facility in relation to allocated sample size. For resource inventory all selected public health facility was audited (23 HFs).

5.6.4.2. Sample size for qualitative data

The key informant interviews were preceded until saturation of information, a total of 14 experienced participants were interviewed and out of this 8 health extension workers and 6 health proofessionals were interviewed. In case of document review all selected health facilities documents of the past 3 months from November 26, 2015 up to January 26, 2016 were reviewed.

5.6.5. Sampling procedure and techniques

For this study all clients whose age in target group (15-49 year) and received the service LAFP either new or revisit during the study period were included in the study. The study was conducted in all public health centers 9 (Gimbichu, Jajura, kosha, Arara, Jukera, Abuna, Humaro, Jacho and Akama HCs) and due to scarcity of financial resource and time constraint 30%(14) of health posts of the district were included this study.(54) And followed lottery/random selection method from catchment HC (Kosha HC; Danatora, and Hangada HPs, from Arara HC; Arara HP, from Gimbichu HC; Sigeda and 1st Hanqota HP, from Akama HC; 1st and 2nd Akama HPs, from Jacho HC; Checho HP, from Humaro HC; 2nd Selfe HP and Bureye Lenge HP, from Jukera HC; Shera HP, from Abuna HC; Benara HP and from Jajura HC; Kecha, and 1st jajura HP) were selected for this study.

A total of 23 public health facilities were included in this study and specific sample size for exit interview allocated to each health facilities using proportion-to-size based on client flow during the last 6 months of year 2015/16. And consecutive sampling technique was used to select the study unit of exit interview. (see figure 3 below)

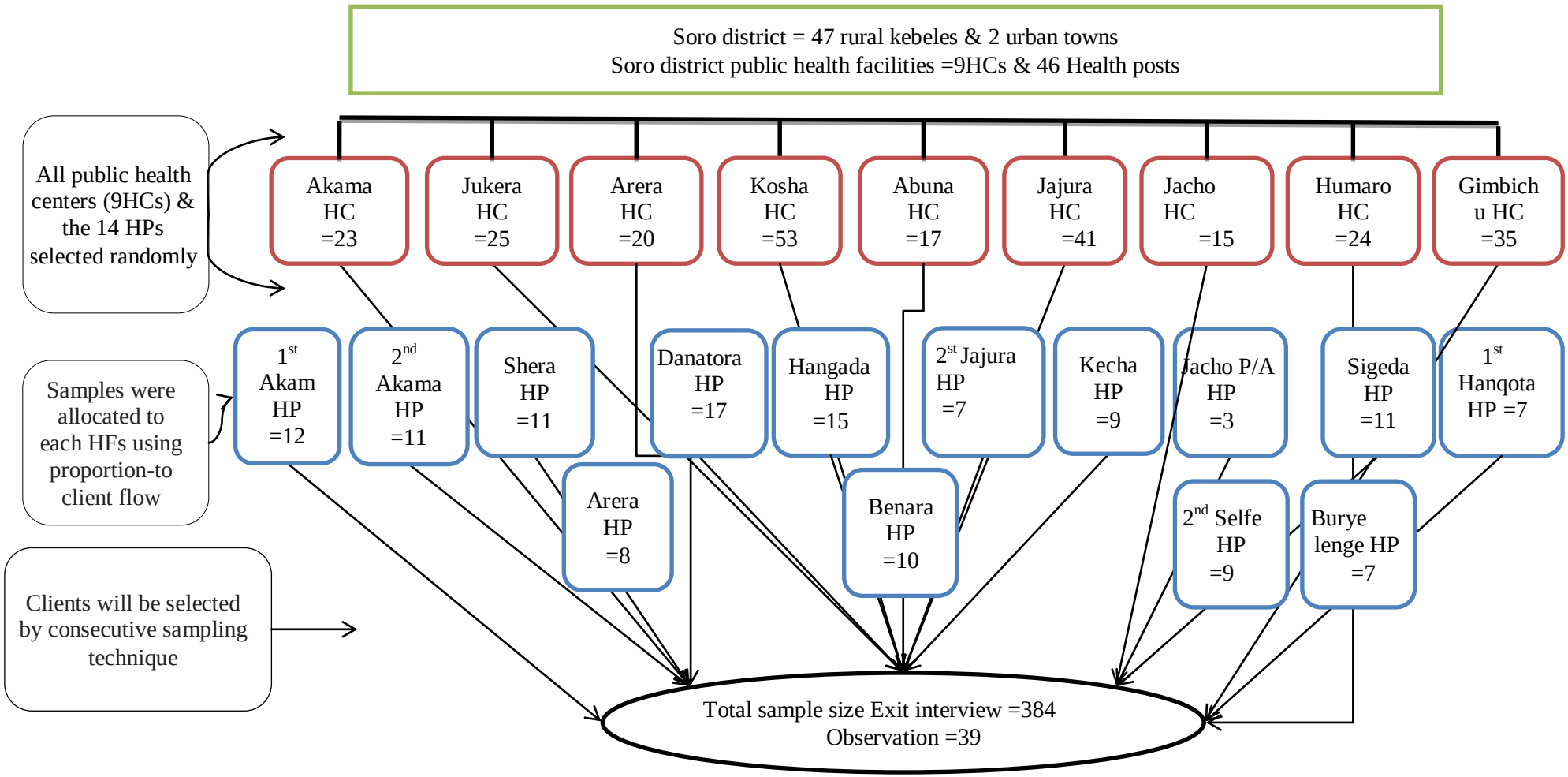

Figure 3**:** Schematic presentation of the sampling procedure of public health facility of Soro district, Hadiya Zone, 2016.

5.6.5.1. Client exit interview

In this particular evaluation client exist interview was used to assess client perception and satisfaction on the service readiness provision through structured questionnaire. It was administered immediately after the service provision. All clients who were utilized long acting family planning service within study period in sampled health facilities were included in this study until the calculated sample size (n=384) was reached. And consecutive sampling technique was used for selection of study units.

5.6.5.2. Observation

Direct observation was conducted to describe the interaction between client and provider, in addition check for documentation and registration of the service they provided in contrast to national guideline. The observations were carried out if client of family planning reach to the FP clinic by providing the clients code and recording here arriving time then counseling proceed up to the clients decided to use the either short term or long term FP methods, the observation of procedures were continue after counseling if the client decided to use LAFP. Structured checklist was administered to 39 observations of the exit interview clients, and the first three cases were rejected to minimize Hawthorn effect. And from all health facilities sample size was proportionally allocated with a minimum of one observation was conduct.

5.6.5.3. Key informant interview

Sami-structured key informant interview guide was used to conduct interview with purposively selected experienced service providers on FP based on information richness. Fourteen key informant interviews were conducted from them 8 were health extension and 6 health workers with experience of family planning provision.

5.6.6. Inclusion and exclusion criteria

5.6.6.1. Exclusion criteria

- Clients who were mentally incompetent were not including in this study for exit interview.
- Service providers with experience less than 6 month were not participating at key informant interview.
- Documents with incomplete information were excluded.

5.7. Data collection

This study tracked different data collection tools to answer the evaluation questions and to meet the objectives of the study design. Quantitative data were collected using adapted validated tool (questionnaires) to assess sub-dimensions related to availability, compliance and accommodation (satisfaction). And qualitative data were collected to enrich findings and investigate the observed level of performance in key informant and breadth. Accordingly, structured questioner was used for exit-interview and structured checklist for observation of compliance and resource inventory was used, semi-structured guiding tool was used for key informant interview and for document review.

5.7.1. Development of Data collection tool

Most of the tool and checklist for this evaluation were adapted from Measure Evaluation "*Quick Investigation of Quality: A user guide for monitoring quality of care in family planning manual no. 2*", *National family planning guideline Ethiopia 2011*, WHO "*A Global handbook for provider 2011 updated*" and reviewing different sources have their own input on the tool.(28, 32, 55-57) The questionnaire for the client exit interview was translated into Amharic then it was translate back to English to ensure consistency of questions. And pre-test was conducted 5% of the total client at health facilities other than the sampled health posts (Harche HP and Sundusa HP) in the district and Kenkicho health center of Duna district. After pretest the quality of the tool further adjustment was conducted to advance the credibility of the tool. Tools that was utilized to capture and judge the program implementation and level of performance of long acting family planning program in public health facilities of Soro district.

5.7.1.1. Facility audit tools

Facility resource inventory was conducted to assess availability of resources to provide long acting family planning service. Information was collected about types of services provided, types and amounts of supplies and equipment in stock, the condition of the facility, and the types of records kept. These were infrastructures, trained human resource, and equipment and supplies, Infection prevention kits, IEC/BCC materials and recording and reporting formats necessary to render long acting family planning service in selected health facilities of Soro district. And also identifies stock and/or frequency of stock out using structured checklist adapted form Measure Evaluation "*Quick Investigation of Quality: A user guide for monitoring quality of care in family planning manual no. 2*".(55)

5.7.1.2. Observation tool

Direct observation with structured checklist was conducted purposively. Aimed to assess the client provider interaction that is a person with clinical training follows the client and evaluates the performance of the provider during counseling and clinical sessions (medical history, physical examination, pelvic examination & method specific clinical procedure (insertion or removal)). And as the same time also assessed the implementation of all component of the service in its natural process in line with national guideline using questioner adapted form Measure Evaluation "Quick Investigation of Quality: A user guide for monitoring quality of care in family planning manual no. 2", National family planning guideline Ethiopia 2011, WHO "A Global handbook for provider 2011 updated", and reviewing different sources have their own input to developed the tool.(28, 32, 55-57) Observation was also use to complement data collected for facility audit/availability dimension/ to ensure that availability of equipment and supplies, recording and reporting format, guidelines, rooms, furniture, IEC materials in family planning health facility including waiting room were really in a place. In the observation, each countable resource were counted and registered in the observation and resource inventory checklist.

5.7.1.3. Key informant interview tool

Key informant interviews with semi-structured guiding question was used to assess general service delivery structure, training status of service providers, their experience and availability of resources, suggestions for improving family planning services in general to explain some of quantitative findings with service providers. Qualitative questions on the commodity management system (i.e., frequency of stock outs, functioning of the system, etc.) It was good to elicit important information on the capacity of the site to provide long acting family planning services.

5.7.1.4. Client exit interview tool

Client exit interview was conducted to collect information about the services they received /experience/ at a given health facility immediately after getting long acting family planning services. Structured questionnaire was adapted from Measure Evaluation "Quick Investigation of Quality: A user guide for monitoring quality of care in family planning manual no. 2" and different researches.(55, 57) That will gather information on socio-demographic characteristics of clients, whether the client was given sufficient information to make an informed choice, how well the client understood the information provided, and their perception and level of satisfaction on the manner in which resources organized to provide long acting family planning service they received. All clients

of long acting FP who will attain to the study HFs at study period were participated until reach sample size of 384 reached but the sample not reached due to the short study period.

5.7.1.5. Document review tool

Structured checklist was used for reviewing documents; includes reviewing reports, records (logbook and tally sheets), charts, formats and plan performance for implementation of long acting family planning program including reporting and recording quality by cross checking data from records to report for the previous 3 months. Check for the way data was recorded on logbook in line with guideline, whereas at health post level reviews the client family folder (integrated card). The tool was adapted from national FP guideline and used to support compliance part of the observation.

5.7.2. Evaluation Team

For exit-interview, direct observation of compliance and resource inventory all data collectors were health professionals(Nurse, Midwifery or Health officer) whether BSc. or diploma with minimum requirement of experience in provision of family planning for one year and/or having training on long acting family planning and they were from other than study facility/area.

Two supervisors were recruited to participate in data collection they have Health officers and experience like exit-interview data collectors in additional they have training on long acting family planning. While in case of document review and key informant interview data was collected by the principal evaluator.

The data collectors were trained on the content of the data to be collected, ethical issues to be addressed during gathering the data, how to communicate with respondents, how to use the data collection guide and tools by principal evaluator 2 days prior to pre-testing the quality of the tool. Supervisors were also trained on the content to be covered during data collectors training, on how to manage data collection process and the way to monitor the quality of data by principal evaluator.

Pre-test was conducted to test quality of tool to advance the credibility of the tool on other than the study health facilities assisted by supervisors and principal evaluator 3 days prior to formal data collection.

5.7.3. Data collection field work

Data were collected from March 7 – April 5, 2016 from respective health centers and health posts. During data collection the data collector reach the health facility before 2:30 A.M local time before the FP clinic opened and data collection was proceed up to 10:30 P.M. And the data was checked for completeness on daily base and appropriate corrections was given by supervisor in addition, the principal evaluator in collaboration with supervisor to handle if problem arise soon as possible. The data was kept in confidential way starting from data collection time by giving code rather than writing participant name and collected from each data collector on daily base. For key informant code was given for participant and the note taken and recorded voice was kept confidential.

5.8. Data management and analysis

5.8.1. Data entry and cleaning

Questionnaires was checked for completeness every day after data collection and any problems encountered was discussed among supervisors and data collectors to be solved immediately in daily bases. Finally the collected data was coded and entered to Epi data version 3.1 for cleaning then entered to SPSS version 20.0. for further analysis. Before analysis necessary transformation was conducted to correct outliers (skeewness). Incomplete, inconsistent or invalid data was treated as missed value and excluded from analysis. Data collected from both observation and resource inventory were entered in to Microsoft Excel 2010 for further analysis.

Qualitative data of key informant interview were taped during interview and in addition note were taken and daily transcribed manually.

5.8.2. Data analysis

Quantitative data from exit interview were checked for completeness, edited, coded, and analyzed using SPSS version 20.0. Bivariate logistic regression was done to see the association in outcome variable and independent variable. Based on bivariate logistic regression, p-value less than 0.25 were selected for multivariate logistic regression to see the effect of confounding variables and p-value less than 0.05 was be statistically significant.

To measure the level of satisfaction of the client, there were 11 questions administered during exit interview with five point Likert scale with score values ranging from 1 (strongly not satisfied) to 5(strongly satisfied) for analysis, each satisfaction item that was analyzed for their frequency (univariate). The client overall satisfaction level was classified in to high satisfaction score above

specific cut point, and low satisfaction below the cut point. Cut point was calculated by using demarcation threshold from formula:

(Total highest score-Total lowest score)/2 + Total lowest score.(50)

All quantitative data except data from exit interview were analyzed by using Ms. Excel 2010. For exit interview data, cleaned data from Epi-data was transported to SPSS for further analysis so that the results were presented in descriptive summery using tables, histogram and charts.

Key informant interview continued until information saturation was reached with 14 service providers (8 health extension workers and 6 health professionals). The interviews were tape recorded and note was taken. All interviews were conducted in Amharic language, as a result the recorded audio data were translated from the Amharic language to English by transcribing into word/written files. Final transcripts were compared against notes to ensure quality. Before the analysis, the text was read through several times to obtain a sense of the hole and familiarize with the data. The various responses were compared based on differences and similarities and sorted into different themes. Quotes that best described the various themes and expressed what was said frequently in several participants were chosen.

Based on parameter of judgment each indicator were measured by computing their agreed score with observed value, the aggregate result of each indicators with in the each sub-dimensions were result value for specific dimensions. The result value of each dimension was aggregated, yielding the actual/total result of implementation level of the program then it was compared with sated implementation judgment criteria to notify the implementation level of long acting family planning.

5.8.3. The following measures were taken to ensure data quality of this Evaluation study

Training was provided for data collectors including supervisors and questionnaire was translated to Amharic and back to English to keep consistency, (5%=19) pre-tested was done before the actual data collection. The completeness of questionnaire was checked by data collectors at the end of the interview and at the end of the day. The principal investigator together with supervisors rechecked completeness of the questionnaire every day and during submission.

To ensure the quality of qualitative data: the transcribed data were compared against notes to ensure quality. And before the analysis, the text was read through several times to obtain a sense of the hole and familiarize with the data.

5.9. Matrix of analysis and Judgment

Matrix of analysis was developed and agreed with stakeholders during Evaluability Assessment along with indicators. The judgment matrix were developed for each dimension of the evaluation with their agreed scores, weight given to each dimensions and observed values. (Annex I)This depicts the standards set by stakeholders after the draft on the dimensions; indicators and judgment are set by principal investigator from FP guideline of Ethiopian each dimension is weighted by the stakeholder using rational method to reach an agreement.

5.10. Ethical clearance

Approval of ethical clearance was secured from Jimma University College of health Sciences ethical committee before the beginning of data collection activity. Prior to the data collection, permission letter was obtained from Hadiya Zone Health Department and Soro district health office and supportive letters was written to health facilities. In addition data collectors explained the purpose of the study, confidentiality and anonymity of the data; and verbal consent was obtained from all study participants, from health facility heads and from all relevant department heads of HC and HEWs after explaining the purpose of the study to them.

Confidentiality of the information given was maintained throughout the process of data collection. The evaluation teams were trained on how to handle sensitive and emotional issues. As matter of utmost respect to the privacy of the studied clients, records was identified only by client card numbers; no client or health care provider name was entered in the data record. Participants of were ensured after receiving consent.

5.11. Evaluation Dissemination plan

Dissemination of findings is important step in the evaluation process because stakeholders should use the evaluation findings timely to take corrective action. The final evaluation report will be presented to Jimma University and valuable comments will be taken. One-day workshop will be organized and all stakeholders will be invited to participate for presentation of the evaluation

findings. In addition, hard and electronic copies of the final report will be disseminated to Jimma University and stakeholders.

Table 2: Dissemination plan for process evaluation of long acting family planning services at public health facility of Soro district, Hadiya zone, Southern Ethiopia, 2016

S.N	Stakeholders & concerned body	Time frame	Responsible body	Dissemination mechanism
1	Jimma University	After final defense of the thesis	Principal evaluator	Face to face submit ion of Evaluation report (Hard and soft copy) Seminar/presentation
2	Regional Health Bureau	Within 15 days after final defense	Principal evaluator	Evaluation report (Hard and soft copy)
3	Hadiya Zone health departments	Within 10 days after final defense	Principal evaluator	Evaluation report (Hard and soft copy)
4	District Health office	Within 10 days after final defense	Principal evaluator	Evaluation report (Hard and soft copy) Presentation/workshop
5	NGO's	Within 10 days after final defense	Principal evaluator	Evaluation report (Hard and soft copy) Presentation/workshop
6	health centers	Within 10 days after final defense	Principal evaluator	Evaluation report (Hard and soft copy) Presentation/workshop
7	Health extensions workers	Within 15-20 days after final defense	District health office	Presentation/workshop

Chapter 6: Result

6.1. Background characteristics of the study population

Data for this study collected through both quantitative and qualitative data collection mechanism aimed to answer the evaluation question and objective of the evaluation. Accordingly a total of 381of study subjects were involved during exit interview, out of this 39 clients were observed for the assessment of compliance the provider in accordance to guideline. During observation session the first three observations were neglected to cop up the study from Hawthorn effect. In addition facility inventory/audit were carried out in all study HFs and key informant interviews were conducted to supplement the quantitative result (six health workers and eight health extension workers were interviewed).

The findings of this evaluation from all the data collection methods either from quantitative or qualitative is organized in three major dimensions. Availability of resource bee it physical or human to provide long acting family planning, the other dimension is compliance of the service provider comply to national guideline during provision of LAFP services and the last dimension is accommodation in the perspective of client satisfaction was measured by 11 items each having five point likert scale. Finally the factors for client satisfaction on LAFP were identified.

6.2. Availability of resource to provide long acting family planning services

6.2.1. Availability of Human Resource

All health posts level two health extension workers were assigned and only 3 HCs (Gimbichu, Jajura and Kosha) have assigned two or more staffs to provide the FP services, all the rest HCs have assigned to provide family planning services only one provider. Majority of the health care providers 55(78.6%) were had over all training on long acting FP. From those who got training 92% of them at least two the health extension workers at health posts level and at least one service providers at health centers trained on Implanon were available, 28(96.5%) of them were health extension workers and 7(77.8%) health centers have at least one service provider trained on Implanon removal and Jadelle each. Generally, 82.5% of service providers were trained on Implant whereas 6(66.78%) health centers were have at least one trained service provider on IUCD(comprehensive insertion and removal) among them two (33.3%) the trained health care

providers were assigned as a head of the health center. None of the HEWs trained in implanon removal procedure.

Most of key informants agreed on the number of trained providers in health facility; they explained about a reason that high turnover and centralization of training in urban settings. Therefore, it leads to provide the service by untrained provider after orientation on the method.

"….. *Mostly training was provided to urban and good performance health centers… Even if it was reach to rural and newly established health centers. Like ours, there is high turnover of trained health professionals from this kind of HFs."* 25 years old female BSc nurse experience of 1 year.

Another 21 year old female clinical nurse with experience of 1 year & 3 month also said *"If the trained health care providers were not in place, we are forced to give the services by untrained provider but who have orientation on the methods, to make the service active and fulfill the choice of the clients..."*

Table 3: availability of trained human resource at health center level to provide long acting family planning service in public health facilities of Soro district, Hadiya Zone, March 2016.

Procedures/methods on which training was received		**Minimum required**		**Available**	
		Per HC	**At 9 HCs**	**Number**	**Percentage (%)**
Implant	Implanon	1	9	7	77.8%
	Jadelle	1	9	7	77.8
IUCD HWs		1	9	6	66.7%
Total			27	20	74.1

Table 4: availability of trained human resource at health post level to provide long acting family planning service in public health facilities of Soro district, Hadiya Zone, March 2016.

Methods on which training was received		**Minimum required**		**Available**	
		Per HP	**At 14 HPs**	**Number**	**Percentage (%)**
Implanon	Insertion	2	29	28	96.5%
	removal	2	29	0	0%
Total			58	28	48.3

6.2.2. Availability of Equipment, Commodities and Infrastructure

A facilities audit (inventory) was conducted in all health center and health post to assess the availability of basic materials (equipment and commodities) and infrastructures. The finding show that only 8(34%) of the health facilities had flash light, for the removal of Implant 3(33%) health centers had no mosquito forceps, 19(82.6%) of the HFs have antiseptic solution out of this all health centers have but 4(28.6%) of health posts had no antiseptic solution. All of the health centers had no referral form and only 4(17.4%) health posts had service delivery tally sheet and also availability of IEC material none of the health facilities had pamphlet and out of 17(73.9%) of the health facilities that had contraceptive samples (that constitute all the methods of FP including LAFP) two (22%) were from HCs and 4(28.6%) were from HP don't have sample of contraceptives.

Table 5: Equipment and supplies available for LAFP at public health facilities of Soro district Hadiya Zone, March 2016.

Instruments and Supplies	Service availability		Equipment used for		Available in HFs		Stock out past 6 months
	HP	HC	Insertion	Removal	No.	%	
Instruments (reusable)							
Flash light	✓	✓			8	34.8%	
Sterilizer/Autoclave	✓	✓	✓	✓	23	100%	
Clean tray	✓	✓	✓	✓	20	87%	
Cup, bowl, or gallipot	✓	✓	✓	✓	19	82.6%	
Holding forceps	✓	✓	✓	✓	15	65.2%	
Mosquito forceps		✓		✓	6	66.7%	
Uterine Sound		✓	✓		9	100%	
Speculum		✓	✓	✓	9	100%	
Tenaculum		✓	✓	✓	7	77.8%	
Mayo scissors		✓	✓	✓	8	89%	
Average Index						80.3%	
Supplies (expendable)							
Pregnancy test		✓	✓	✓	8	89%	Yes
Sterile surgical drapes	✓	✓	✓	✓	18	78.3%	No
One pair of sterile gloves	✓	✓	✓	✓	23	100%	No
Antiseptic solution	✓	✓	✓	✓	19	82.6%	Yes
Local anesthetic (lidocane)	✓	✓	✓	✓	23	100%	Yes
5 ml syringe with needle	✓	✓	✓	✓	23	100%	No

Instruments and Supplies	Service availability		Equipment used for		Available in HFs		Stock out past 6 months
	HP	HC	Insertion	Removal	No.	%	
Sterile gauze	HP	HC	✓	✓	23	100%	No
Average Index						95.8%	
LARC contraceptives							
Implants - Implanon	✓	✓	✓		23	100%	No
- Jadelle		✓	✓		9	100%	Yes
IUCD		✓	✓		9	100%	No
Average Index						**100%**	
Recording and reporting							
Recording- log book		✓	✓	✓	9	100%	
- Integrated card	✓		✓	✓	14	100%	
- Tally sheets	✓	✓	✓	✓	4	17.4%	
Referral form	✓	✓	✓	✓	0	0%	
Reporting format	✓	✓	✓	✓	21	91.3%	
Average Index						61.7%	
EIC material							
Posters	✓	✓	✓	✓	18	78.3%	
Flip chart	✓	✓	✓	✓	20	87%	
Broacher/ pamphlet	✓	✓	✓	✓	0	0%	
Contraceptive sample	✓	✓	✓	✓	17	73.9%	
Average Index						59.8%	

✓ Indicate the equipment must be important to which HFs with respect to the availability of service and for which service the equipment and supplies used for

The finding of key informant interviewers show that most of the health providers don't give concern on referral form while refer clients to other health facility for the methods that was not available in the health facility.

"... We are not referring clients for FP service to other health facility including hospital, as a result we are not familiar to use referral form and also it was not available in this HF. But, in case some health extension workers refer clients to us, but they were using a piece of paper or they send clients without any written paper. Due to this clients were not get the service as soon they reach to the facility." 23 year old female Midwifery nurse with experience of 3 years and 7 months.

All long acting family planning methods IUCD, Implanon and Jadelle were available throughout the data collection date & three months prior to the study period. However, Jadelle stock out was occurred during the last six months once more than 30 days in all health centers, this is due to due to expiry of the contraceptive. In addition Lidocane was stock out in 7 health posts(Sigeda, 1st Akama, 2nd Akama, O/Lenge, 2nd Selfe, Kecha and Shera HPs) and 3 health center (Akama, Humaro and Gimbichu Hs) in the past 6 month. During data collection period Arara health center stock out pregnancy test (HCG) and 5 health posts (G/Lenge, Odiacho, 2nd Akama, Benara and Wesheba) HPs stock out of antiseptic solution was experienced more than 30 days.

Participant of key informant interview show their hand for the season for stock out of the supplies was PFSA and all health offices from WoHO up to Regional Health Bureau. A 28 year old male HO with experience of 5 years and 7 years assigned as MCH team coordinator replied that:

"... when the time of stock out we asked the district health office with formal letter but it was not solved urgently .....Mostly this was the mandate of PFSA. Occasionally during Lidocane stock out in this health facility the same thing is there at PFSA, conditions like this can hinder the program to achieve its objective and limit the choice of FP methods. Even if we like to buy and avail from private pharmacy and drug store the system forbidden to do that."

Condition of Facilities and Amenities (Infrastructure)

All of the health facilities except Akama HC the service had no separate rooms for physical examination instead the service integrated to MCH especially with ANC. Thirteen (56.5%) health facilities had functional light source (electricity or solar energy) from the entire health center had and four health posts had electricity or solar energy. Whereas only 9(39%) of the health facilities had piped water 5 health centers had and only 4 of the health posts had piped water. The health facilities were availing the water from the nearby water source (spring) and using rain water collection mechanism. Only in Gimbichu HC the waiting area has fulfill all the requirements: shade, clean, furnished with bench and entertainment (TV with satellite dish and CD player), the remaining health centers had fulfill the standard the other except entertainment but the health posts not furnished well, instead the clients were waiting at shade place around the tree and on the lay ground. The waiting area had an average occupancy of 15 client in the health centers and 5 clients at health posts. All materials, equipment and supplies were protected from rain and sun at all the

health facilities but 8 health posts had no adequate space on the shelf for storage instead they use Carton for storage as well off the floor.

The key informant interview shows that the infrastructures to give the service were limited and some of them were made the program not to goes well and in line with national guideline. Even if it was change to them they create different strategies to minimize its effect on the clients and program in general.

"... most of the time we are working on by bought water from our home for daily consumption, this is due to our heath facility not accessed piped water and the spring water source is far away from the facility…this has increase a burden for us in our daily activity." 31 years old HEW with service experience of 10 years.

"...this health center upgrade from clinic to HC standard without expansion of rooms for all service according to standard, as a result some related service merged in one room like FP and MCH. These make the service and client to not safeguard their privacy and waiting long time to gets the service…" 25 years Midwifery with experience of 5 years and assigned as MCH team coordinator

IEC Materials and Guideline

Only four health facilities (17.4%) were had bill- board or displayed posters about FP in and around the facility campuses, out of this none of the health posts displayed. From the 23 health facilities different IEC materials were available in 18(78.3%) HFs there were FP posters from those all of the health centers had, 20 (87%) flipchart and 17(73.9%) had contraceptive samples. None of the health posts and health centers had anatomical models, pamphlets and leaflets. Only seven health facilities (30.4%) were had standard FP guideline revised at 2011, Humaro and Abuna HCs and all of the health posts were had no FP guideline.

Result from interview on the availability of guideline that the guideline was not introduced to most of the service providers especially at health post level. And they explained that:

"Mostly the trained health care providers were not brought manuals and standard guideline provided for them during training to the health center. Instead they were taking to their home…" 26 year old male clinical nurse with experience of 3 year.

And also 29 years HEW with 7 year experience reflect *that "…from the time when I assigned as HEW for this kebele I am not familiar with national guideline, we are asked mostly during WoHO supervision we replayed them the same thing…."*

Table 6: Judgment Matrix of availability dimension of resource to provide long acting family planning service in public health facilities of Soro district, Hadiya zone, March 2016.

Dimensions with indicators	Weight given	% Observed	Observed score	Judgment parameter
Availability (40)				
Number of service providers who receive in-service training on long acting methods	12	78.6%	9.4	
Proportion of HFs having basic instrument /equipment for provide long acting FP	15	80.3%	12	
Proportion of HFs having all long acting FP contraceptives in accordance to	12	100%	12	**[85 –100] -V. Good**
Proportion of HFs having supplies for provide long acting FP	15	95.8%	14.4	**[75– 84] -Good**
Proportion of HFs having at least one FP guideline	12	30.4%	3.7	**[60-74] – Fair**
Proportion of HFs having separate FP room	8	8.7%	0.7	**[< =59] – Poor**
Proportion of HFs having IEC material for each service of long acting FP provided by HF	10	59.8%	6	
Proportion of HFs experience stock out of long acting contraceptive for more than 30 days in the last consecutive 6 months	7	33.3%	2.3	
Proportion of HFs having all recording & reporting formats (logbook, tall sheet, report sheet)	9	61.7%	5.6	
Average scores of Availability (100%)			**66.1%**	

6.3. Compliance of family planning service provision in public health facilities of Soro district

6.3.1. Counseling of Family planning

Provision of counseling to new and repeat clients in line with national guideline is one of the components of long acting family planning services. About two hundred sixty fourth of clients (70.6%) responded that time to communicate with provider was about right, 81(21.7%) said time

was short, 17(4.5%) said too long and 9(2.4%) did not want to respond. Three hundred seventy seven (91.5%) clients responded provider was easily understandable, 26(6.3%) said difficult to understand, and 9(2.2%) did not want to speak about providers. Three hundred thirty two clients were encouraged to ask a question during counseling by the provider, and 294(79.7%) clients were asked some questions to service provider about contraceptive methods, out of these 211(74%) were satisfied with the answer given by service provides, 33(11.6%) partially satisfied, and 31(10.9%) were not satisfied. Client waiting time was recorded and the Mean+SD waiting time was 29.6+0.9 minutes with range of 2-124 minutes. Two third of the waiting time were acceptable that was (less than 30 minutes).

From 39 observation session 32(81%) were new and 7(19%) were repeat clients counseled from the observed counseling rapport building (greet client and offer seat, make introduction and assure confidentiality & privacy) for clients were according to national guideline.

Around 32% of new visit clients were not counseled on exploration; 18(58.9%) were not explore the issue related to sexual life, 16(52.9%) were not explore their knowledge/history and 14(44.1%) were not explored their relationship and circumstances. Eighteen (52.9%) of clients were don't got the explanation about the method not safeguard against STIs and AIDS and also 23(67.6%) of them don't told about the procedure was performed the method the client accepted. (See table 6 below)

Table 7: Observation result of long acting FP counseling process for both new and repeat clients in public health facilities of Soro district, Hadiya Zone, March 2016.

S. N	**Did the provider (n=32)**	**New clients (n=32)**		**Revisit client (n=7)**	
		Complied	Not complied	Complied	Not complied
Rapport building					
	Does provider greet client with respect	32(100%)	0(0%)	7(100%)	0(0%)
	Make introduction	28(87.5%)	4(12.5%)		
	Assure confidentiality & privacy	28(87.5%)	4(12.5%)		
	Average index	**91.7%**	**7.33%**	**100%**	**0%**
Exploration					
	Ask for the reason for the visit	27(85.3%)	5(14.7%)	6(87.5%)	1(12.5%)
	Explore client knowledge, intention and concern about FP and give additional explanation	20(67.6%)	12(32.4%)	-	-
	Ask the satisfaction with the current method			6(87.5%)	1(12.5%)

S.N	Did the provider (n=32)	New clients (n=32)		Revisit client (n=7)	
		Complied	Not complied	Complied	Not complied
	If there is dissatisfied with the current method, did explore the reason and discuss for possible solutions			7(100%)	0(0%)
	Ask reproductive history and fertility plan	25(76.5%)	7(23.5%)		
	Explore clients circumstance & relationship	18(55.9%)	14(44.1%)	7(100%)	0(0%)
	Explore issue related to sexual life	13(41.1%)	19(58.9%)		
	Ask about STI/HIV knowledge/history & help to perceive risk	15(47.1%)	17(52.9%)		
	Rule out pregnancy	32(100%)	0(0%)		
	Average index	**67.6%**	32.4%	**93.7%**	**6.3%**
Decision making					
	Did the provider help the client to make an informed choice/her own decision?	32(100%)	0(0%)	7(100%)	0(0%)
	Ask the client identify what service needed during this return visit (resupply, follow up)			7(100%)	0(0%)
	Average index	**100%**	**0%**	**100%**	**0%**
Implementation					
	Provide information about family planning choices	32(100%)	0(0%)		
	Did the provider utilize IEC materials during consultation?	32(100%)	0(0%)	3(37.5%)	4(62.5%)
	How the method works	31(91.2%)	1(8.8%)		
	The side effects of the method	32(100%)	0(0%)		
	Explain method does not protect against STIs and AIDS?	15(47.1%)	17(52.9%)		
	Explain how the procedure will be performed the method accepted?	11(47.1%)	22(67.6%)		
	Help the client in implementing the decision (continue the current method, switch other method, discontinue the method)			7(100%)	0(0%)
	Make follow up plan if applicable	32(100%)	0(0%)	7(100%)	0(0%)
	Average index	**83.6%**	**16.4%**	**79.2%**	**20.8%**

6.3.2. Choices of FP informed to clients during counseling observations

Those clients who receive counseling were informed the two components of family planning choices short acting and long acting methods. Accordingly from short acting methods 36(92.9%) of the client were informed about pills and 4(9.5%) were informed about spermicides, 38(97.6%) were told about injectable as a method of family planning and information about condom and diaphragm were provided to 26(69%) and 7(21.4%) of the client respectively. And from long acting family

planning 2(4.8%), 39(100%), 19(52.4%), 24(61.9%) and 5(16.7%) were informed about Sino II implant, Implanon, Jadelle, IUCD and Sterilization methods of family planning respectively.

During all observations the service providers utilized one or more IEC materials, poster predominately utilized 31(74%), followed by sample of contraceptive 27(64%) and 20(47.6%) were utilized flip chart.

Most of the key informants agreed that they give more emphasis to some methods; based on its side effect, based on the currently given emphasis method by the government and based on the clients feeling on her mind. Mostly clients thinking about one method in her mind and talking with others especially for services that were done away from the health facility by referral not acceptable by clients.

"... now a days mostly I am not informed to clients choices that are not performed/available at this health facilities because clients were not have an intention to go and got the services. As a result As a result I give emphasis on choices of the FP methods that we have in this facility..." a 32 years old male clinical nurse with service experience of 7 and half years.

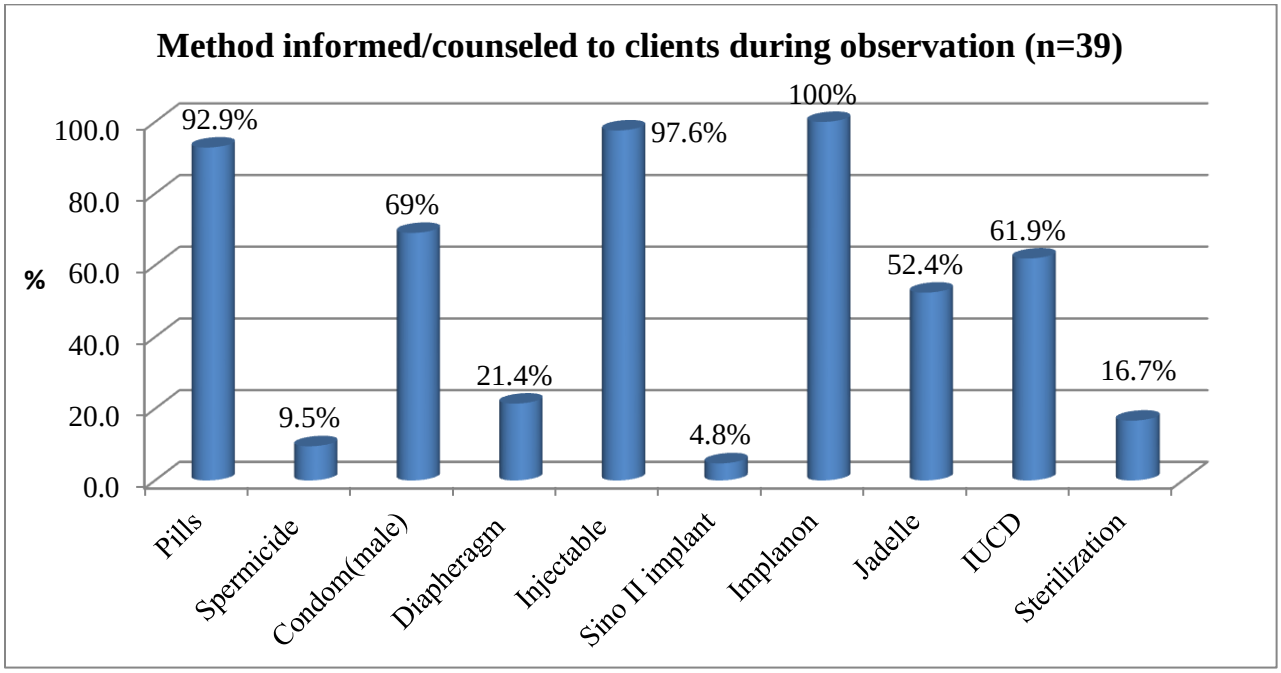

Figure 4: Choice of family planning methods informed to client during counseling at public health facilities of Soro district Hadiya Zone, March 2016

6.3.3. Basic information given to the clients

During counseling process the service providers were provide information on key issues in relation to long acting family planning in particular family planning in general. Accordingly 322(90.6%) of the client were informed about how the method work, 352(92.4%) of them informed about the side effect of the method used. Other information provided included the possibility of switching 234 (61.4%), what to do if problem arise before the next visit 245(64.3%) and where to go for resupply 251(65.9%) of clients were informed.

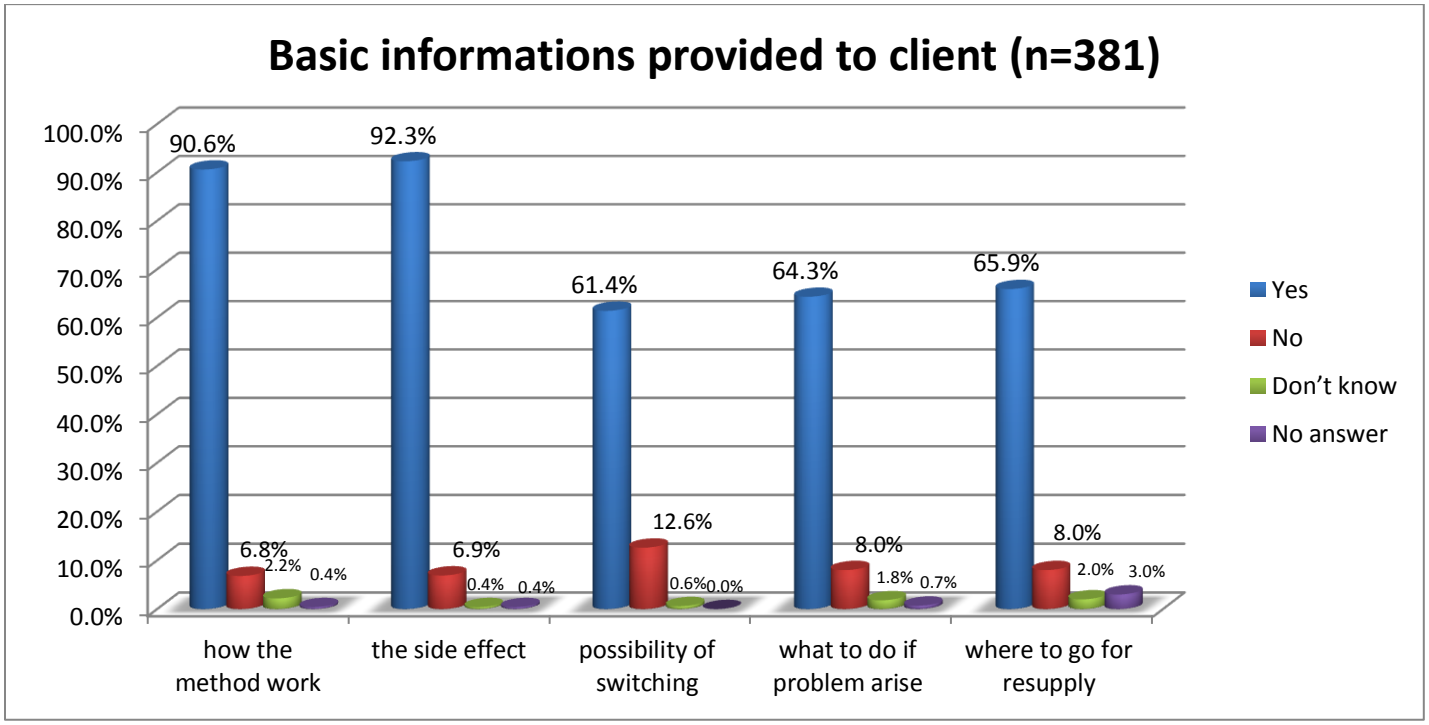

Figure 5: Bar chart for exit interview client's information given to client of long acting family planning counseling in public health facilities of Soro district Hadiya zone, March 2016.

6.3.4. Physical examination and Clinical procedures during observation

From the observed clients 7(19%) were revisit (repeat) and 32(81%) of them were new clients and out of this 34(88.1%) of clients were used Implanon and 5(11.9%) were IUCD users. Out of 34 Implanon clients 27 were new inserted clients then the rest were revisit (repeat) clients.

The result show that 5(12%) of the observed procedures were carried out by untrained health care provider at two health center by providing Implanon insertion service. Physical examination and medical history for clients were conducted during counseling, from the observed clients 39(100%)

were asked their contraceptive history and about the date of LMP and 32(100%), 30(93.7%) and 26(81%) were assessed unusual vaginal discharge, sign and symptom of STI including HIV/AIDS and pelvic pain respectively. Thirty six (92.8%) clients were measured their weight and measure blood pressure and 25(64%) were performed physical examination. At the health center level from the observed 24 clients 5(19%) were not test their pregnancy in laboratory/HCG. From all the observation 22(56.4%) were underway through ensure privacy of the client and 12 (44.4%) were explain the procedure of the method followed to the clients. (See table 7 below)

Table 8: clinical procedure followed for implant (implanon) at public health facilities of Soro district Hadiya zone, March 2016

S.N.	During Implant (Implanon) inserted the provider did (n=27)	Complied	
		Yes	No
1	Ensure privacy before procedure	22 (82.7%)	5 (17.2%)
2	Explain the procedure follow	12 (44.4%)	15 (65.6%)
3	Prepare all instrument before the procedure	22 (81.5%)	5 (18.5%)
4	Allow a time for local anesthetic to take effect prior to incision	27 (100%)	0 (0%)
5	Ask client to wait/rest for at least 15 minutes after insertion	15 (55.6%)	12 (44.4%)
6	Instruct client regarding (wound care and return visit)	20(74%)	7 (26%)
	Average index	73.6%	26.4%

Five intrauterine contraceptive device (IUCD) insertion procedures were observed during data collection period 2 from Kosha HC and Jajura HC and one from Gimbichu HC. In all the procedures providers were adhere with national clinical guideline by ensuring privacy, by preparing all instrument before the procedure. Whereas 2 observations were conduct speculum exam for STI, use Tenaculem, and 3 clients were ask to wait/rest for at least 15 minutes after procedure. (see table 9 below)

Table 9: clinical procedure followed for IUCD at public health facilities of Soro district Hadiya zone, March 2016

S.N.	During Intra uterine Contraceptive Device (IUCD) inserted provider did (n=5)	Complied	
		Yes	No
1	Ensure client has privacy	5	0
2	Prepare all instrument before the procedure	5	0
3	Explain the procedure follow	5	0
4	Conduct speculum exam for RTI/STIs before bimanual exam	2	3
5	Conduct bimanual pelvic exam	4	1
6	Use tenaculum	2	3
7	Sound the uterus before IUD insertion	4	1
8	Ask client to wait/rest for at least 15 minutes after insertion and removal	3	2
9	Give post insertion instructions (how to check IUCD in a place)	4	1
	Average index	72.5%	27.5%

Before Implanon insertion/ clinical procedure 23(86.2%) providers were used sterilized high level disinfected instrument for the procedure and 15 (55.2%) providers were wash hands before put on disinfected gloves. Before incision of the skin 21 (74%) were clean the skin with antiseptics, and all the procedures utilized new needles and syringes for local anesthetics and allow a time for clients to take the anesthesia its effect. After the procedure 19 (70%), 15 (55.5%) and 20 (74%) of providers were wash their hand, ask the client to take a rest after procedure and instruct the client regarding wound care and return visits respectively. (See table 8 &10)

Table 10: Infection prevention procedure followed during long acting FP service at public health facilities of Soro district Hadiya zone, March 2016.

S.N.	Infection prevention procedures	Implant (n=27)		IUCD (n=5)		Total
		Yes	No	Yes	No	Yes
1	Use sterilized or high-level disinfected instruments	23(86.2%)	4 (13.8%)	5(100%)	0 (0%)	88.2%
2	Wash hands before putting on gloves	15 (55.2%)	12 (44.8%)	3(60%)	2(40%)	56%
3	Cleaned the skin or cervix with antiseptics	21 (74%)	6(26%)	4(80%)	1(10%)	76.5%
4	Use new needle and syringe for local	27(100%)	0 (0%)	NA	NA	100%

	anesthetic					
5	Use the no-touch technique for inserting the IUD	NA	NA	5(100%)	0 (0%)	100%
6	Wash hands after removing gloves	19 (70%)	8 (30%)	5(100%)	0 (0%)	73.5%
7	Ensure that instruments and reusable glove decontaminated	24(89.7%)	4(10.3%)	5(100%)	0 (0%)	91.2%
8	Disposal of sharp or wests in puncture resistant container (safety box) or waste container	27 (100%)	0 (0%)	5(100%)	0 (0%)	100%
	Average index					85.7%

Service providers ensure all reusable material and object were decontaminated for all implant and IUCD insertions. Service providers put sharps in puncture resistant container and waste in waste container for all procedures of Implanon and IUCD insertion.

6.3.5. Referral and follow-up mechanism

During the whole observation session discussion on referral was not conducted by service provider, neither for services like (MCH) nor for FP methods available in other HFs. In addition data from document review show that no clients referred to other level for family planning service by using standard FP referral format.

Finding from most of the key informant interview show that there is no follow up mechanism of tracing of clients who were inserted LAFP methods to check whether they were using or switch the method.

"… during counseling we told for clients about revisits date after one year and whenever problem faced. Mostly they were coming when they encountered side effects unless they return when they remember the appointment date at any time, client forget the appointment date. But she was reported annually until she was discontinuing the method." 23 years Midwifery with experience of 4 year and 9 month.

"As a system there is no active mechanism /strategies to trace defaulters' clients… I remember my experience about problems related to that one client coming after delaying a year from the appointment of removal… " 27 years old female health extension worker with experience of 6 year and 5 months.

Table 11: Judgment matrix for compliance dimension of the evaluation of long acting FP services at public health facility of Soro district Hadiya zone, Southern Ethiopia, March 2016.

Dimensions with indicators	Wight given	% observed	Observed score	Judgment parameter
Compliance (35)				
Proportion of client counseled on rapport building according to national guideline	10	92.1%	9.2	
Proportion of client counseled on exploration according to national guideline	10	67.7%	6.8	
Proportion of clients made informed chose /decision	6	100%	6	**[85 –100] -V. Good**
Proportion of clients counseled on long acting FP by aid of at least one IEC materials	8	100%	8	**[75– 84] -Good**
Proportion of client got basic information on the method accepted (possibility of switching, side effects…)	10	75%	7.5	**[60-74] – Fair**
Proportion of client informed about the procedure (insertion & removal) of the selected method	6	72.4%	4.3	**[< =59] – Poor**
Proportion of LAFP service provision procedures followed infection prevention procedure according to national guideline	12	85.7%	10.3	
Proportion of clients discuss on follow-up and revisits	10	100%	10	
Proportion of client got instruction on wound care or check for IUCD in place(post insertion counseling)	9	78%	7	
Proportion of HFs that follow consistence of recording and reporting the last 3 months performance	10	73.8%	7.4	
Proportion of health facilities refer clients to next level using standard referral form	5	0%	0	
Proportion of health facilities having follow up mechanism for tracing clients of LAFP	4	0%	0	
Average scores of Compliance (100%)	100%		**76.4%**	

6.4. Survey (client exit interview) result on client satisfaction of service accommodation

6.4.1. Socio demographic characteristics of the client exit interview respondents

Client exit interview was conducted to assess client satisfaction on long acting family planning service provided by Soro district public health facilities through administered structured questioner with dimension of accommodation. Accordingly the data were collected from 381 respondents from twenty three long acting family planning service delivery points.

Two eighty three (74.3%) were rural dwellers and from the total respondent 279 (73.2%) were new clients and rest were return (repeat) clients. The mean age of the respondent' was 28 SD + 5.3 years old with range between 16-44 years. From the age group of participants 155(41.2%) were between 25-29 years old. About 353(92.9%) were married, and out of this 322(84.5%) were married and live together with their husbands, 16(4.2%) were not married (single), the rest were widowed and divorced. From those who were married and live together with their husband 225(69.7%) respondents had discussed with their husband about FP. Three hundred sixty two (95%) had children, out of this 127(33.3%) had 3-4 children. From those who had children, 202(52.8%) were mothers with breast-feeding at the time of data collection. The majority of the clients, 183(48%) were illiterates (unable to read & write) and 106(27.8%) were read and write and 92(24.1%) were high school completed and above. Almost all members of the study population 319(83.7%) were Hadiya by ethnicity, the rest were Kembata, Amhara and Gurage. Majority of contraceptive users 259(68%) were Protestant and regarding to occupation, two hundred seventy five (72.2%) were housewife. (Table 11)

Table 12: Socio-demographic characteristics long acting family planning service client at public health facilities of Soro district, Hadiya Zone, 2016

Socio demographic characteristics of exit interview participants (n=381)	Frequency (n=381)	Percent (%)
Age(years)		
15-19	11	2.9
20–24	**65**	**17.3**
25–29	**155**	**41.2**
30–34	84	22.3
35+	61	16.2
Client frequency of visit		
New	**279**	**73.2**
Revisit (repeat)	102	26.8
Residence		

Socio demographic characteristics of exit interview participants (n=381)	Frequency (n=381)	Percent (%)
Rural	**279**	**74.2**
Urban	97	25.8
Marital status		
Single	16	4.2
Married & live together	**322**	**84.7**
Married but not live together	31	8.2
Divorced	7	1.8
Widowed	4	1.1
Educational level of participant		
Unable to read & write	**183**	**48**
Write & read only	106	27.8
Primary(1–8th)	54	14.2
Secondary(9–12th)	23	6
Higher education	15	3.9
Ethnicity		
Hadiya	**319**	**83.9**
Kenbata	44	11.6
Gurage	5	1.3
Amhara	10	2.6
Others **	2	0.5
Occupation		
Government employee	20	5.2
Private employee	9	2.4
Merchant	32	8.4
Un employed	11	2.9
House wife	**275**	**72.2**
Student	23	6
Daily laborer	11	2.9
Religion		
Orthodox	66	17.3
Muslim	16	4.2
Protestant	**259**	**68**
Catholic	40	10.5
Living child		
0	25	6.6
1-2	121	31.8
3-4	**127**	**33.3**
5+	108	28.3
Discuss with Husband about FP		
Yes	**225**	**69.7**
No	94	29.1
Monthly Income		
<200	41	12.1
201-500	**161**	**47.4**
501-1000	90	26.5

Socio demographic characteristics of exit interview participants (n=381)	Frequency (n=381)	Percent (%)
1001-2000	42	12.4
2001-3000	6	1.8
>3000	0	0

**Wolaita and Oromo

6.4.2. Method of long acting family planning received

Respondents were asked during exit interview the method they chosen/received in their visit; majority of respondent were received Implanon comprised of 356(93.5%), and followed by IUCD (6%) and the remains were Jadelle implant. (Figure 6)

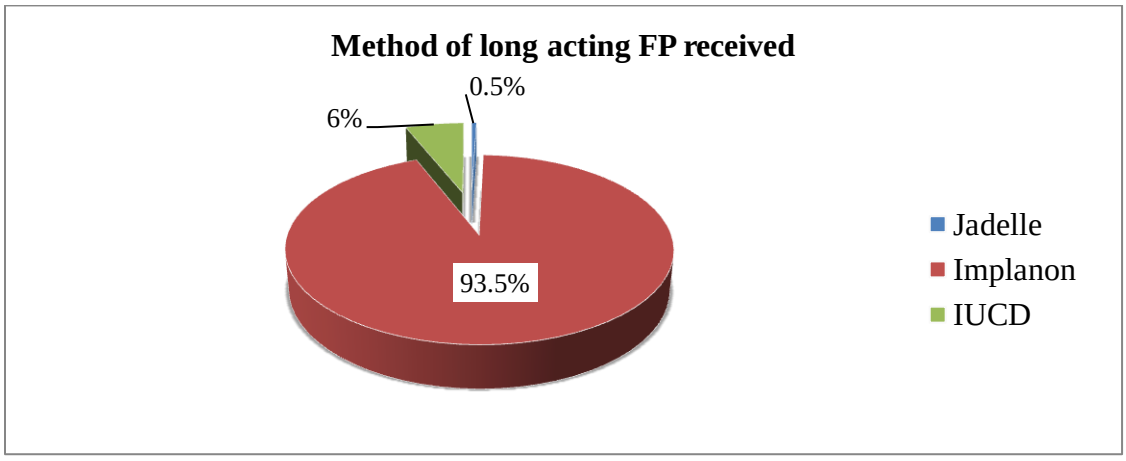

Figure 6**:** Types of long acting family planning method received by exit interview participants at public health facility of Soro district, Hadiya zone March 2016

Finding from key informant interview show that implanon is becoming one of the widely used FP methods, like injectable/Depo Provera in their catchment health center and HPs.

*"…now a day in this catchment health center and its satellite health posts most women show high interest to use Implanon. When we have discussion with mothers during "mothers forum" some women share their experience on FP that mostly they expressed that implanon have possibly of lower side effect compare to others method they used. "*26 years old female clinical nurse with experience of 3 years.

6.4.3. Client satisfaction level on service accommodation of long acting FP service in public health facilities of Soro district

This evaluation measure the level of satisfaction as an outcome variable for this particular evaluation research to determined their satisfaction using 11 measurement items each having Lickert scale value 1-5 from strongly not satisfied to strongly satisfied. Finally the result was dichotomized in to satisfied and not satisfied, by using demarcation threshold formula: {(total highest score-total lowest score)/2 + total lowest score. For this study the expected maximum and minimum replay were 55 and 11 respectively but the result were relay on 55 maximum and 23 minimum finally by computing the formula the result gives as 39 which was a threshold. And values below and value above the threshold were considered not satisfied and satisfied respectively

Clients during exit interview were asked all (11) measurement items to choose their satisfaction from the five options to each items. Three hundred forty (89.2%) were agreed on satisfaction (strongly satisfied or satisfied) on provider approach and satisfaction on distance between home and health facility two third of the respondent 65.1% were strongly satisfied or satisfied, but in case of availability of different methods majority 300(78.8%) of respondent were satisfied (strongly satisfied or satisfied) and 6.6% were neutral; And also with maintenance of privacy, 156(40.9%) were strongly satisfied, 92(24.1%) were somewhat satisfied, 39(10.2%) were neutral, 84(22%) were somewhat not satisfied and the rest10 (2.6%) were strongly not satisfied.

Satisfaction on time management: waiting time to get a service of FP 112(29.6%) were strongly satisfied, 194(50.9%) were satisfied and the time took for counseling were satisfactory (strongly satisfied and satisfied) to 316(83%) respondents. In the case of health facility service house 301(79%) were satisfaction (strongly or not) and on the number of days the service availability 291(76.4%) respondents were satisfied (strongly satisfied or satisfied).

Satisfaction on condition of health facilities: consequently 156(40.9%) respondent were not satisfied (strongly not satisfied or not satisfied), 151(39.8%) of them were satisfied (strongly satisfied and satisfied) on availability of functional latrine and water in the facility. Around 58% were expressed their strongest satisfaction & satisfied on waiting area and also 222(58.3%) satisfied either strongly or not on the cleanness of health facility. (Table 12)

Table 13: Clients satisfaction level on service accommodation of long acting FP service at public health facilities of Soro district Hadiya zone, March 2016.

S. N	Satisfaction items on Accommodation dimension	Strongly not satisfied	Not satisfied	Neutral	Satisfied	Strongly satisfied
		No.(%)	No.(%)	No.(%)	No.(%)	No.(%)
1	Approach of service providers	5(1.3%)	16(4.2%)	20(5.2%)	130(34.1%)	210(55.1%)
2	Distance between home and HF	13(3.4%)	95(24.9%)	25(6.6%)	105(27.6%)	143(37.5%)
3	Sufficient method available at the HF	6(1.6%)	37(9.7%)	38(10%)	163(42.8%)	137(36%)
4	Time took for counseling	3(0.8%)	20(5.2%)	42(11%)	185(48.6%)	131(34.4%)
5	Waiting time adequate	7(1.8%)	42(11%)	26(6.8%)	194(50.9%)	112(29.6%)
6	Privacy maintained	10(2.6%)	84(22%)	39(10.2%)	92(24.1%)	156(40.9%)
7	Waiting area suitable	19(5%)	112(29%)	28(7.3%)	99(26%)	123(32.3%)
8	Condition of latrine and water	47(12.3%)	109(28.6%	74(19.4%)	108(28.3%)	43(11.3%)
9	Cleanness of health facility	14(3.7%)	90(23.6%)	54(14.2%)	134(35.2%)	89(23.4%)
10	Number of days service are available	4(1%)	67(17.6%)	19(5%)	149(39%)	142(37.3%
11	Hours of service at HF	2(0.5%)	60(15.7%)	18(4.7%)	146(38.3%)	155(40.7%)

6.4.4. Factor affecting client satisfaction on service accommodation of long acting FP

One of objective this evaluation research is assessing factors related with client satisfaction on service accommodation. So, bivariate logistic regression analysis was done to identify variables having association with client satisfaction on service accommodation of long acting family planning. In this analysis variable including frequency of visit, information, distance travel in time from home to HF, opening hour of the HF, Plan when to have next child in year, understandability of counseling, and socio-demographic variables(age, residence, marital status, education, occupation, religion, ethnicity, number of child, family size, and income) were tested. However, in this analysis frequency of LAFP visit, distance between home to HF, plan to have next child, understandability of consultation, and socio-demographic variables (age, education, marital status, family size and income) were found significant association with client satisfaction ($p<0.25$).(see table 13)

Table 14: Binary logistic regression analysis result of client's satisfaction on service accommodation of long acting family planning in public health facility of Soro district Hadiya zone, March 2016.

Variables		Frequency	Client satisfaction		P-value	COR	95% CI	
			Not satisfied	Satisfied				
			Count	Count			Lower	Higher
Residence (n=381)	Rural	283	107	176				
	Urban	98	42	56	.378	1.234	.774	1.967
Visit (n=381)	new	279	120	159				
	repeat	102	29	73	.000	.223	.126	.395
Age (n=376)	15-19	11	4	7	.350	.521	.133	2.043
	20-24	65	29	36	.011*	.370	.171	.800
	25-29	155	65	90	.010*	.412	.210	.811
	30-34	84	34	50	.029*	.438	.209	.917
	35+	61	14	47				
Marital status (n=380)	single	16	6	10				
	Married	353	136	217	.934	.957	.340	2.694
	Divorced	7	5	2	.147*	.240	.035	1.649
	Widowed	4	1	3	.642	1.800	.151	21.477
Plan of next child (n=235)	up 3 year	48	12	36	.014*	.316	.126	.791
	3-5 yr	37	19	18	.052*	.503	.251	1.006
	up to> 5 yr	296	118	178				
education level (n=381)	No formal education	289	120	169	.065*	2.817	.939	8.451
	Primary school	54	11	43	.001*	7.818	2.215	27.600
	Secondary school	23	8	15	.059*	3.750	.949	14.821
	higher education	15	10	5				
Religion (n=381)	Orthodox	66	22	44	.509	.688	.227	2.087
	Muslim	16	7	9	.312	.748	.426	1.314
	Protestant	259	106	153	.433	1.410	.597	3.329
	Catholic	40	11	29				
Ethnicity (378)	Hadiya	319	138	181	.445	.525	.100	2.745
	Kenbata	44	7	37	.422	2.114	.340	13.154

Variables		Frequency	Client satisfaction		P-value	COR	95% CI	
			Not satisfied	Satisfied				
			Count	Count			Lower	Higher
	Amhara	10	2	8	.683	1.600	.168	15.273
	Others	7	2	5				
Occupation (n=381)	Government employee	20	6	14				
	Merchant	32	10	22	.924	.943	.280	3.174
	Un employed	286	117	169	.340	.619	.231	1.658
	Daily laborer	11	3	8	.873	1.143	.223	5.866
	Others	32			.440	.626	.191	2.056
Monthly income (n=340)	<200	41	18	23	.309	2.556	.420	15.553
	201-500	161	63	98	.198*	3.111	.553	17.490
	501-1000	90	33	57	.165*	3.455	.600	19.893
	1001-2000	42	12	30	.084*	5.000	.806	31.002
	2001-3000	6	4	2				
Distance travel (n=370)	<1/2 hour	154	75	79				
	½-1 hour	172	57	115	.004*	1.915	1.224	2.998
	1-2 hour	42	9	33	.002*	3.481	1.561	7.762
	>2 hour	2	1	1	.378	.593	.186	1.895

* Significant <0.25

Those variables significant (p<0.25) for bivariate analysis, their association with client satisfaction were tested and analyzed for multivariate logistic regression analysis using backward LR method. Therefore, those variables having significant association with client satisfaction on service accommodation of long acting family planning service were identified as predictor of client satisfaction. As a result of multivariate analysis result show that frequency of visit, education level of the clients, time took for travel distance from home to HF and plan when to have child/birth were found to be the predictors of client's satisfaction on service accommodation. (See table 14)

Table 15: Multivariate logistic regression analysis result of client's satisfaction on service accommodation of long acting family planning in public health facility of Soro district Hadiya zone, March 2016.

Variables		Frequency	Client satisfaction		P-value	AOR	95% CI	
			Not satisfied	Satisfied				
			Count	Count			Lower	Higher
Visit (n=381)	new	279	120	159				
	repeat	**102**	**29**	**73**	**.000**	**.166**	**.080**	**.346**
Plan of next child (n=235)	up 3 year	48	12	36				
	3-5 yr	**37**	**19**	**18**	**.015**	**.213**	**.062**	**.740**
	up to> 5 yr	**296**	**118**	**178**	**.030**	**.349**	**.135**	**.902**
education level (n=381)	No formal education	289	120	169	.550	1.522	.384	6.039
	Primary school	**54**	**11**	**43**	**.004**	**10.597**	**2.084**	**53.887**
	Secondary school	23	8	15	.269	2.594	.478	14.075
	higher education	15	10	5				
Distance travel (n=370)	<1/2 hour	154	75	79	.516	1.676	.352	7.973
	½-1 hour	172	57	115	.103	3.658	.768	17.424
	1-2 hour	**42**	**9**	**33**	**.020**	**8.053**	**1.396**	**46.447**
	>2 hour	2	1	1				

Accordingly those clients who received family planning service for more than one frequency/revisit were 88% less likely satisfied with long acting family planning service compare to new clients (AOR=0.116, 95% CI=0.08, 0.346). Clients who plan to have the next child/space more than 5 years were 65% and client who planned to have child with in 3 to 5 years were 79% less likely satisfied as compared to clients planned to have child less than three years (AOR=0.349, 95% CI=0.135, 0.902) and (AOR=0.213, 95% CI=0.062, 0.740) respectively. Those clients who took a time for travel a distance from their home to HF between one hour up to two hours were 8 times more satisfied as compared to those who take a time more than two hours (AOR=8.053, 95% CI=1.396, 46.447). In addition those clients who were primary in education were 10.6 times more likely satisfied with long acting family planning service as compared to those who attended higher education.

Table 16: Judgment matrix for satisfaction of client on accommodation of long acting FP services at public health facility of Hadiya zone, Southern Ethiopia, 2016.

Dimensions with indicators	Weight given	% Observed	Observed score	Judgment parameter
Satisfaction (Accommodation) (25)				
Percentage of client satisfied by the approach of service provider	5	89.2	4.5	[85 –100] -V. Good [75– 84] -Good **[60-74] - Fair** [< =59] - Poor
Percentage of client perceive the availability of sufficient LARC methods	11	78.8	8.7	
Percentage of client perceive the distance between home and service delivery point convenient	8	65.1	5.2	
Percentage of client perceive that the counseling time is convenient	12	83	10	
Percentage of client perceive waiting time at service delivery point is short	13	80.5	10.5	
Percentage of client satisfied by privacy during counseling	12	65	7.8	
Percentage of client satisfied by waiting area	10	58.3	5.8	
Percentage of client satisfied on HFs having functional latrine & piped water	7	39.6	2.8	
Percentage of client satisfied by cleanliness of the facility	8	58.6	4.7	
Percentage of client satisfied with number of days LAFP services is available	7	76.4	5.3	
Percent of client satisfied by working hours of the facility	7	79	5.5	
Average scores of Satisfaction (100%)			**70.7%**	

The overall level implementation of long acting family planning service in public health facilities of Soro district Hadiya zone; it is achieved **FAIR** and with the overall judgment result of **70.8%** according to the sated indicators.

Table 17: Overall judgment matrix and analysis of long acting family planning services at public health facility of Soro district Hadiya zone, Southern Ethiopia, 2016

Dimension	**Weight given**	**Present achieved**	**Observed score**	**Judgment criteria**
Availability	40	66%	26.4	**[85 –100] -V. Good**
Compliance	35	76.4%	26.7	**[75– 84] –Good**
Accommodation	25	70.7%	17.7	**[60-74] – Fair** **[< =59] - Poor**
Total score	**100**	**71%**	**70.8**	

Chapter 7: Discussion

This study has attempted to evaluate the process/implementation of long acting family planning program in public health facilities of Soro district, Hadiya Zone, Southern Ethiopia. Maintaining an adequate and safe family planning service in general and long acting FP in particular is an issue of concern to government of Ethiopia particularly local health planners especially with increase in demand as a result of the decreases in population size and problems related with pregnancy. Therefore, understanding the level of implementation of long acting family planning is crucial to identify important and basic decision making information to primary stakeholders including Soro district management bodies and other stakeholders to optimally ensure the organization to meet its strategic objectives of the program.

The result of this study shows that a diverse age group of women in reproductive age who have received LAFP contraceptive services, from them age group between 20-29 years were 57.8 % which shows as high reproductive need in this age group, this finding was similar with studies conducted in Jimma Zone59.5% and 65.4% in Bahir Dar specialized Zone.(45, 57) This indicates that high reproductive need observed in this group. So the program intervention becomes effective while its focuses are on this age group.

In this study the most commonly used long acting family planning method was found to be the Implant (94%) almost all were Implanon (93.4%) and followed by the IUCD (6%). Study conducted in African has shown that use of Implanon has been progressively growing, here in Ethiopia 17 fold increased, like implants IUDs has steadily increased in sub Saharan Africa.(13) This result was similar with study conducted in Nekemet Implant account for (77.6%) and 14.9% where IUCD.(58) In this is due to Implanon appears to be the most preferred family planning method perhaps the service was available in all of the health facilities(HPs & HCs) than IUCD and Jadelle(HCs).

Most of the respondent replied during the key informant interview that mostly clients preferred to use Implanon from all long acting. They expressed that due to different reasons for like increase in awareness, lower side effect…etc.

A 25 years old male clinical nurse with experience 2 years support this idea that *"...now a day in this catchment health center and its satellite health posts most women prefer to use Implanon. When we have discussion with mothers during "mothers forum" some women share their experience on*

FP that mostly they expressed that implanon have possibly of lower side effect compare to others method they used. ".

7.1. Availability of resource to provide long acting FP

The finding from assessment of general HFs condition show that the official working hours for all of the selected health facilities were from Monday to Friday were 8:30 am to 5:30 pm except for lunch time (12:30 am-1:30 pm). But during the assessment date most health posts 8(57.2%) were not opened at the official time, so the service was not provided at the official working hour. Study conducted in all district health facilities of Ethiopia show that FP services were provided five days in a week in most health facilities and clients who presented for services reported that facilities with FP services were close by and had convenient hours of operation.(59) Other study conducted in Jimma zone in the year 2003 that only Limu Genet Health Center was not providing FP service in the morning hours.(45) The main reason for the difference was both HEWs have similar schedule for an activity called house to house visit, so that the health posts were closed during that schedule. As a result clients were not satisfied with the waiting for long time to get services.

This study find out that all LAFP methods IUCD, Implanon and Jadelle were available throughout all the public HFs of Soro district during data collection date & three months prior to the study period. However, Jadelle and Lidocane stock out were occurred during the last six months. This was similar with study in all district health facility of Ethiopian on FP situational analysis that availability of FP methods was high, in the facilities that usually provided IUCDs, 93% had it in stock at the time of the survey, facilities were generally well stocked, but some facilities occasional stock outs were experienced in the past six months.(59) Another study identified that stock out of the necessary commodities or equipment can be problematic.(6) Study in Nigeria reflects the unavailability of a desired method can lead to discouragement and the decision to postpone use. (60) This study show some improvement related to FMOH objective on scale up of IUCD from 2014-2017 that availing IUCD services in 86% of the intervention facilities.(14)

According to WHO, to provide LAFP appropriately trained personnel must be available in order for those methods to be offered.(29) According to current study majority 95.3% of the health care providers were trained on Implanon insertion, hence 97% were health extension workers and 77.8% health professional from 7 health centers and also (77.8%) health centers have at least one service provider trained on Implanon removal and Jadelle insertion and removal each. Generally 83.6% of

service providers were had training on Implant (Implanon & Jadelle) insertion & removal, whereas 66.78% health centers were had trained service provider on IUCD (comprehensive insertion & removal). This study somewhat show some progress compare to situational analysis of FP in Ethiopia that half of the providers had received training in IUCD insertion, and 52% had received training in IUCD removal. And also, nearly 60% had received training in implant insertion and removal. In comparison, 37% of the HEWs had received training in Implanon insertion.(59) But high variation was observed compare to FMOH scale up of IUCD objective that was an average of 2 trained IUCD providers per facility from 2014 up to 2017.(14)

Other studies done in four African countries on barriers of LAPMs identified one of the barrier was lack of widespread training of providers. Whereas in case of study done in Nigeria show that providers complained of high workload due to an insufficient number of trained providers, and there were also problems with lacked of necessary training to provide LA/PMs, this problem also leads to increased waiting time for clients.(5, 60) The differences were resulted from that now a day the concern of Ethiopia government to work hard on scale up program to trained all HEWs and 2 health professional at health center level up to 2017 on the scale up of long acting family planning program now a day.(14) Result from different literature show that training yields positive results for providers and clients, it can reinforce providers' positive interpersonal skills, discourage giving excessive information, and reorient providers toward an interactive, exploratory process of helping clients.(61) As a result of unavailability of trained service providers malpractices of providing LAFP was experienced this study finds out that 12% of the observation were conducted by untrained service providers.

The finding from key informant interview support this finding that most of key informants agreed on the unavailability and only one trained health care provider in health facility is due to high turnover and centralization of training in urban settings. Therefore, it leads to provide the service by untrained provider after orientation on the method.

By this study only seven health facilities (30.4%) were had a copy of FMOH guideline of FP service in Ethiopia revised at 2011. This was similar with study done in Jimma zone show that only 3 SDPs (37.5%) had a copy of guideline of FP.(45) When we saw other study done by Fekru T., et al. in year 2013 somewhat the finding deviated that all of the health centers had no standard FP guideline. (44) According to FMOH the guideline has an objective of be a guide to all cadres of

health care providers directly or indirectly involved in the provision of FP services.(62) the difference with the study done by Fekru T., et al. in year 2013 was this study included health posts whereas differences in HCs level were minimum.

In the case of availability of electricity and water supplies by this study 56.5% of the health facilities had functional light source (electricity or solar energy), whereas only 9(39%) of the health facilities had piped water, out of this 55.6% health centers and 28.6% of the health posts had piped water. Due to this season providers were not to adhere with guideline to ensure infection procedure especially hand washing practice and sterilization of equipment and also to keep the facility clean. Generally the study of situational analysis of FP in Ethiopia reported that the service environment and infrastructure were good; but basic infrastructure was limited in health posts, including water availability. (59). Other study done in Jimma zone in year 2003 showed as all SDPs had clean water supply.(45) Another study conducted in Nigeria show that some facilities did not have electricity, and those that did may only have had power intermittently.(60) All the mentioned studies were difference in infrastructure due to difference in setting and resources the study area cover.

By this study only one health facility have separate room for provision of FP service. As a result to maintain client auditory and visual privacy was so difficult. The finding seems similar to report of FMOH Ethiopia that in most health facilities the space or room for the provision of family planning is integrated with other reproductive health programs. (63) In contrast study done Fekru T., et al. in year 2013 reflect that all of the health centers had separate rooms for physical examination.(44)

7.2. Compliance of service provision

Providing accurate and reassuring information to women and couples about family planning is an essential component of family planning promotion and advocacy. (1)

By this study Implanon, Injectable and the pills were the most commonly discussed methods to clients by the providers 100%, 97.6% and 92.9% respectively, which may have an impact on give clients restricted choices. This was similar result with study conducted in Bahir Dar special Zone, injectable (97.1%), pills(95.6%) and implant(72.1%) were most commonly discussed methods. (57) Other study in Debre Markos indicate that 52.6% of respondent discuss about LAPMs out of this 45.5% were Implanon.(47) Finding from key informant interview of provider in qualitative study in Adigrat town that the counseling service they were providing was not inclusive of all modern contraceptives.(43)

According to National guideline information provided to client was method mix in central to quality of service, the FP program should focus on highly effective contraceptive methods with particular emphasis on long-term methods.(62) Then the variation was due to the fact that currently the government set an objective to reach 50% LAFP from overall FP users to achieve this objective health care providers intension/inclination to LAFP, in addition to this trained on long acting family planning methods can have its own contribution to the difference.

Most of the key informants agreed that they give more emphasis to some methods; based on its side effect, based on the currently given emphasis method by the government and based on the clients feeling on her mind.

In general this study find out majority of respondent (51.4%) also responded that there was no adequate/auditory and visual/ privacy during counseling. This study is similar with study conducted in Northwest Ethiopia (66.3%) were respond inadequate privacy.(64) Other study on quality of FP show (70.1%) clients replayed their privacy was maintained.(57) This difference is due to availability of separate FP room.

During the counseling session, the use of IEC materials the client specially a groups that have low literacy rates helps clients understand key information and helps the provider remember important points. (61) During all observations of this study the service providers utilized at least one or more IEC materials; poster predominately utilized 74%, followed by sample of contraceptive (64%) and 47.6% were utilized flip chart. This study seems different with study conducted in Northwest Ethiopia, that in none of the consultations did the provider use flip charts, brochures/pamphlets, or other IEC materials except for samples of contraceptives that was used in 19(22%) of the consultations. (64) And another study identified different from the above that counseling session utilized most were contraceptive 56.8%, followed by flip chart 35.2%, poster 29.5% and5.7 % used anatomic model. (57) Their difference with Bahir Dar special Zone study was this study focused on public health facility only not that of NGO' and with other was based on health care providers training currently and availability of EIC material.

According to world health organization for those methods that require surgical approaches, insertion, fitting and/or removal by a trained health provider appropriate infection prevention procedures must be followed.(29) Hand washing practices before and after performing the procedures of this study was 56.5% and 73.5% of providers of this study were washed their hands

before and after procedure respectively which was similar to study done in Northwest Ethiopia that is 58.2% and 66.2% of the provider were follow hand washing practice before and after procedure respectively. (64) Whereas the study in Bahir Dar special zone that 12.5% of the providers washed their hands before procedures.(57)

Certain information on family planning methods is now considered essential to aid that decision making. (61) On the provision of basic information to the client during counseling in this study 90.6% of clients informed about how the method work, 92.3% of clients informed about on the possible side effects, 61.4% of clients informed about possibility of switching and 64.3% of clients informed about return to HF at any time problem arise. Study done in same region SNNPR (Arbaminch) shows that 74.3% of the respondent discussed about problems related with FP method whereas study of Bahir Dar special zone depict that around two third of the respondent were got explanation/information about how the method wok, side effects and return problem arise and 80% explain possibility of switching the method.(48, 57) Other study in Northwest Ethiopia identified that 29% of clients informed the possible side effects of the methods.(64) But according to national FP guideline Information should be provided regarding all available methods of contraception used, Advantages and expected contraceptive side effects as well as the steps to be taken if and when the clients have side effects.(62) this difference was a result of the providers trained on long acting in recent time.

There was similarity of this study with study conducted in Northwest Ethiopia that both studies there is no discussion held between provider and client on referral, as a result no referrals were made during the whole period of observation. (64)

This study illustrate different result found on waiting time that the mean+SD waiting time was 29.6+0.9 minutes with range of 2-124 minutes. For two-third (65%) of clients the waiting were acceptable that was (less than 30 minutes). But in the case of Jimma Zone in year 2013 show that the mean+SD waiting time of clients before getting service was 16.4+18.1 minutes with range of 3 - 180 minutes. In general, the waiting time was acceptable (within 30 minute) to 92.4% of the clients. (44)The main reason for this difference was this study include health posts in which providers were not assigned to provide only FP service instead they provided all service in the same time including FP and majority of the health posts were not opened on official working hour.

All public health facilities in Soro district don't have defaulter tracing mechanism/follow up after insertion of LAFP this finding similar to study conducted in Bahir Dar all family planning service delivery points did not have any means of tracing defaulters.(57) According to national FP guideline of Ethiopia include follow up as a main task for provision of FP in all level of health care.(62) the providers mainly concerned on insertion and side effects but not about those clients probably not familiarized side effect who were not visited to health facility after insertion.

7.3. Client satisfaction on service

One principal determinant of uptake and continued utilization of family planning services is overall client satisfaction with those services.(49) To determine the level of satisfaction of clients on the manner in which public health facilities of Soro district were organized to provide long acting FP different satisfaction question were asked & responded by providers. Accordingly waiting time to get a service of FP 80.5% were satisfied (satisfied and strongly satisfied). The result seems similar with study done in Jimma zone (93.4%) were satisfied (agree and strongly agreed) by the waiting time.(44) Study conducted in four African country, waiting times were nearly always considerably longer at public facilities, at public sector health centers roughly 40% of clients reported problems with waiting times at public clinics in Kenya.(49)

In the case of availability of different methods, majority 78.8% of respondent were satisfied (strongly satisfied or satisfied) and 6.6% were neutral. This finding was perfectly similar with study conducted in Bahir Dar special zone that was 78.6% respondents agreed on availability of different methods.(57) Concerning time took for counseling (83%) respondents were satisfactory (strongly satisfied and satisfied), and in the case of health facility working hour (79%) were agreed on satisfaction (strongly or not). Study in Jimma show that (94.4%) and 97% of the respondents were satisfied (strongly satisfied and satisfied) on sufficiency of consultation time and clinic working hour conveniences respectively.(44)

And also with maintenance of privacy, (40.9%) were strongly satisfied, (24.1%) were satisfied, (10.2%) were neutral, (22%) were somewhat not satisfied and the rest (2.6%) were strongly not satisfied. It looks similar with study conducted in Jimma zone that with the maintenance of privacy, 55.6% were strongly satisfied, 35% were somewhat satisfied, 6.1% were neutral, 2.8% were somewhat not satisfied and the rest 0.5% were strongly not satisfied.(45)

Concerning on cleanness of health facility 58.3% satisfied (strongly or somewhat) on the cleanness of health facility while 27% were not satisfied. The finding of this study identified different result compare with other studies, study conducted in Hossana town show that 88.3% of participant were satisfied. (50) And also study in Jimma reflected 89% respondents were satisfied on cleanliness of clinic area.(44) Another study conducted in four African countries indicated that highest levels of dissatisfaction were with the cleanliness of public health centers, for which 12% of respondents reported a problem.(49) The reason for the difference was availability of having water source in most health facilities were not available.

Consequently 40.9% respondent were not satisfied (strongly not satisfied or not satisfied), (39.8%) of them were satisfied (strongly satisfied and satisfied) and the rest were neutral on availability of latrine and water in the facility. Study show that 66.5% agreed on availability of latrine and water in the waiting place.(57)

7.3.1 Factor affecting client satisfaction on long acting FP service provision in Soro district

In the multivariate analysis result frequency of visit, education level of the clients, time took for travel distance from home to HF and plan of the next child/birth were found significant predictor of client satisfaction in public health facilities of Soro district. Education level was identified as factor of client satisfaction in study conducted in Jimma zone and this is consistent with this evaluation finding.(44) Another study done in Hossana town support the finding of the current study that frequency of visit was one of the predictor of client satisfaction.(50)

7.4. Limitations of the study

Since the study was facility based it might have been overestimate the results related to satisfactions. It is possible that not satisfied clients might not come to health institutions. It is recognized that limitations that may arise from providers who had shown their best behavioral responses during the observation of client provider interaction (Hawthorne effect). Moreover, clients had shown courtesy bias during the exit interview.

Chapter 8: Conclusion and Recommendations

8.1. Conclusion

Several shortfalls in implementation of long acting family planning program service provision have been identified by this evaluation:

Regarding the availability of resources (physical or Human) this study find out that; insufficient number of training providers were available especially on IUCD the main reasons for this was high turnover. Most of the public health facilities don't have Ethiopian National guideline revised in 2011; it can guide the providers to comply accordingly and to work hard fulfill the minimum package requirement of the health facility to provide long acting FP. Almost all health facilities were FP room was not isolated instead the service was mostly in the same room with ANC this make difficult to keep the client confidentiality and privacy.

Most of the health facilities lack infrastructures like water and electricity this make difficult to follow standard infection prevention procedure and to keep the facility clean. Most health facilities don't have dispensary tally sheet for contraceptive and standard referral form for family planning service. There was stock out long acting family planning contraceptive /Jadelle/ and Lidocane for more than 30 days once times in the last 6 months prior to data collection period. Generally the overall availability dimension judgment was fall in FAIR category.

Concerning on the compliance of providers in line with national FP guideline during counseling and procedures, the judgment was fall in GOOD category against to that almost all public health facilities were no follow up mechanism for clients after insertion of long acting family methods but report annually without confirmation of the client used the method or not. The finding also shows that all health facilities not followed standard referral system for the method available at other health facility. During counseling clients were somewhat counseled on exploration but informed to the client about the procedure the method followed during insertion and removal was not given attention by providers. All procedures in used at least one IEC material during counseling, discuss about follow up visit and help the client to informed choice decision were highly emphasized by providers. Mostly providers not follow hand washing practices before and after the procedures.

Judgment on the service accommodation where perceived/satisfied by clients were FAIR with respect to sated criteria. Mostly clients were reflected that the waiting area, availability of

functional latrine and water, cleanness of the health facility and maintenance of their privacy during counseling was not satisfied with. In addition this study also established that possible barriers to long-acting methods uptake include frequency of visit, plan when to have a child, education level and the distance to home to HF were well-known barriers for satisfaction of client on service accommodation.

The evaluation result of this study concluded that the overall implementation of long acting family planning program in public health facilities of Soro district was FAIR as per-sated judgment criteria with key stakeholders during EA phase.

8.2. Recommendations

The findings from this study have important implications for program improvement, demand generation and service provision. Below are recommendations to strengthen the FP program in general and long acting FP in particular in public health facilities of Soro district:

Even if the national guideline endorsements to health extension workers to provide implanon removal, but according to this study health extension works were not trained to provide the service and not done yet. So, the FMOH needs to switch on the program sooner by advancing the skill of HEWs to provide the service, unless the guideline needs a revision on this part.

The Soro district administration and concerned sectors will be expected to allocate budget and working hard to solve the problems of basic infrastructures (electricity and water) by sitting priority to health centers and accordingly.

The Soro WoHO has to communicate with or in collaboration with Zone health department, Regional health Bureau and other NGO's bodies to increase number of trained staffs and design a strategy that can enable to minimize frequent turn over. Provide training including refreshment training. In addition professionals who attained special trainings will be expect to be free from any extra duty including management.

Health facilities in collaboration with governmental and/or non-governmental organizations should give a credit to advance the availability of different infrastructures (electricity and water), separate FP room, also making waiting area suitable to accept client, availing the National guidelines, standard referral form and dispensary tally sheets and sign announcing that the availability of

LAFP service. Health facilities in collaboration with PFSA work hard to minimize stock-outs and the regular availability of supplies and equipment needs.

Health providers be it health worker or health extension works should washed their hands always before and after the procedures. And those who were not got training should stop malpractice of providing long acting FP, instead strengthen the referral system. During counseling the providers need to be providing all basic information concerning about the methods available in the facility and others methods that were done in other health facilities including hospital. Health providers integrated with health facility need to design follow up strategies to reach clients that were not visit annually after insertion of long acting family planning method. This all can help to limit gaps that were depicted by this study during compliance/client provider interaction in relation to national guideline.

The health facilities again give emphasis to minimize those issues that most of the clients were not satisfied with the service accommodation; about privacy (either visual or auditory), waiting area suitability and cleanness of the health facility. Service provided at all SDP would active the service of LAFP according to service requirement as a result clients were not exposed to travel more than 2 hour to get the service so this enable the client satisfaction was travel distance. During provision of service health care providers give attention to clients that want to space more than 3 years that mean clients of LAFP used Jadelle or IUCD due to this the clients were satisfied on the their decision they made for spacing.

Chapter 9: Meta evaluation

Evaluation of the evaluation was conducted after performing all the procedure to synthesis the final report of this evaluation by principal evaluator; this is due to resource constraint and unavailable of evaluator near to the study area who supports this study Meta evaluation was conducted by evaluator himself. By using standardized checklist adopted from American Joint committee of Evaluation. (65) With 4 standards: As a standard of utility the evaluation of the evaluation show that **= 22 (Very Good),** as a standard of feasibility the evaluation of the evaluation show that **= 5 (Fair),** as a standard of prosperity the evaluation of the evaluation show that **= 18 (Good),** and as a standard of accuracy the evaluation of the evaluation show that **= 23 (Good).** The major subcomponents through each standard were discussed in below.

9.1.Utility Standard

During EA all stakeholders were engaged, those who have an interest on the program were clearly ensured and identified. This evaluation ensures stakeholder need on the evaluation question, indicators and judgment value based on their agreement. The evaluator was ensure credibility by competing enough (professional and experienced) and perform activity as far as his professional limit other issues were consulted with other professionals. The evaluator was made sure that the collected data are answering the stakeholder most important evaluation question (merit and worth). And In order to increase the likelihood of the evaluation utility the evaluator encourage and confirm the stakeholders to participated throughout the evaluation level from planning up to reporting and following. The report of this thesis was avoided jargon, ambiguity and uncertainty, so it was presented in way that comprise of clear description. Final report will be disseminated as planned timeline that enhance the effective utilization of evaluation report by key stakeholders.

9.2.Propriety Standard

Formal written agreement on the evaluation was on hand basically on the indicators and judgment value that safeguard to develop mutual respect and trust between evaluator and stakeholders.

This evaluation was designed and conducted in a way that protects the welfare dignity and right of all stakeholders with whom they interact in the course of evaluation and the participants are not threatened or harmed. The evaluation was completed and fair in its examination and recording of strengths and weaknesses of the program being evaluated and conclusion and recommendations was reached to stakeholders in clear with in short period for improvement of the program.

9.3.Feasibility Standard

In order to minimize disruption the evaluation procedures were practical, to alleviate problems related to this issues the evaluator make sure that the method used for this theses is fit for the study and minimal. Twenty three data collectors and 2 supervisors were recruited for data collection. They were recruited from other than study facility to minimize bias and one days training were provided on the data collection tool for both supervisors and data collectors & also pre-tested the tool away from sampled study area were carrying out. This thesis was recognized, monitored and balanced the difference between culture and politics of the study area, through the anticipation of different position of interested group or individuals in the study obtain support and recognition from leaders and stakeholders.

9.4.Accuracy Standard

To maintain this evaluation accurate information was collected, processed, and reported in an evaluation systematic through reviewed of the collected information and detect if there is any errors were corrected. The evaluation was described the program emphasis on program component (the way program are functioning and working) to gain an understanding that the program inputs or resources, the activities or process and the short term/outcome and long acting/ impact. All procedures that the evaluation was followed and pass through were described. The information was gathered in relation to focus of evaluation and the evaluation questions of the study and applied variety of data collection methods to address those evaluation questions with detail description. To keep the validity different approaches were used during information gathering like recruit professionals on health working and have experience in FP, provided training on the data collection tools, pre-test for check the quality of the tool and field work data completeness check.

Reference

1. FHI360(USAID). Facts for Family Planning 2012. Durham, North Carolina: FHI360/Communication for Change Project. 2013:1-118
2. FMoH[Ethiopia]. Family Planning: Blended Learning Module for the Health Extension Programme. 2010:1-152.
3. World Bank. Trends in Maternal Mortality : 1990 to 2013. 2013:1-68.
4. State of the World 2012 - Moving Toward Sustainable Prosperity: Overpopulation Solutions - Everything Connects, availiable at: http://www.everythingconnects.org/overpopulation-solutions.html, accessed in December 2015 [internet].
5. Neukom J, et al. Dedicated providers of long-acting reversible contraception: new approach in Zambia. Contraception. 2011;83(5):447-52.
6. Monica W. et al. Family health research: A forum for putting knowledge into practice. 2008;2(1).
7. Family Planning in Africa: Long-Acting and Permanent Methods(2012).
8. Blumenthal P, et al. Strategies to prevent unintended pregnancy : increasing use of long- acting reversible contraception. Human Reproductive Update. 2011;17(1):121-37.
9. WHO et. al., Ensuring human rights within contraceptive service delivery : implementation guide. 2015:1-64.
10. WHO et. al., Family planning: a health and development issue, a key intervention for the survival of women and children. 12. 2012;23:1-4.
11. USAID et. al., Three Successful Sub-Saharan Africa Family Planning Programs : Lessons for Meeting the MDGs. 2012.
12. UN. The Millennium Development Goals Report 2015. New York: 2015.
13. Duvall S, et al. Scaling up delivery of contraceptive implants in sub-Saharan Africa : operational experiences of Marie Stopes International. Glob Health Sci Pract. 2014;1(2):72-92.
14. FMOH[Ethiopia] F. Scale up of Implanon and IUCD in Ethiopia. In: Team FPC, editor. Addis Ababa: availabile at (www.fmoh/gov/et//Family Planning - Ministry of Health.htm); 2015.
15. CSA [Ethiopia] ea. A New release of population growth of Ethiopia. 2015 (January):1-3.
16. UNFPA. A decade of change in contraceptive use in Ethiopia 2012 (December):1-64.
17. CSA [Ethiopia] et al. Ethiopia Mini Demographic and Health Survey 2014. 2014:1-111.
18. CSA[Ethiopia], Ethiopia Demographic and Health Survey 2005:Preliminary Report(2005).
19. CSA[Ethiopia]. Ethiopia Demographic and Health Survey 2011. 2012 March.
20. CSA[Ethiopia], Ethiopia Demographic and Health Survey 2000(2001).
21. Population Reference Bureau[PRB] and Ethiopia Economic Association [EEA]. The Demographic Dividend : An Opportunity for Ethiopian's Transformation. 2015 (October):1-24.
22. FMOH[Ethiopia], Health Sector Transformation Plan (HSTP). 2015 (Augest):1-166.
24. UN Secretariat, World Contraceptive Patterns 2015. New York: 2015.
25. Maristops international et.al., Long-term contraceptive protection, discontinuation and switching behaviour: intrauterine device (IUD) use dynamics in 14 developingcountries(2011).
26. Soro WoHO, Health Sector Woreda Base Plan 2016, monitoring and evaluation team June (2015).

27. WHO. Ensuring human rights within contraceptive programmes. 2014:1-50.
28. FMOH[Ethiopia], National Guideline For Family Planning 2011 (February):1-65.
29. World Health Organization(WHO). Selected Practice Recommendations For Contraceptive Use. 2004:1-170.
30. Mota K, et al. Unmet need of long-acting and permanent family planning methods among women in the reproductive age group in shashemene town , Oromia region , Ethiopia : a cross. BMC Women's Health. 2015;15(51):1-8.
31. Yalew SA, et al. Demand for long acting contraceptive methods and associated factors among family planning service users ,Debre-Tabore town, Northwest Ethiopia : a health facility based cross sectional study. MBC Research note. 2015;8(29):1-10.
32. World Health Organization Department of Reproductive Health and Research (WHO/RHR) and Johns Hopkins Bloomberg sophCfCPC. Family Planning: A Global Handbook for Provider (2011 update). WHO Ca, editor. Baltimore and Geneva2011. 1-212 p.
33. Patient information:Long term methods of birth control(Beyond the basics), [internet] accessed 25 Dec. 2015. availible at: http:/www.uptodate.com/contents/long-term-methods-of-birth-control-beyond-the-basics [Internet].
34. FHI et. al., Family Planning: For Ethiopian Health center team(2003).
35. UNFPA. Programme Manager ' s Planning Monitoring & Evaluation Toolkit Tool Number 4 : Stakeholder Participation in Monitoring and Evaluation. 2004 (Augest):1-12.
36. Rossi et al. Evaluation: a systematic approach SAGE Publications; 1999. 511 p.
37. Center for disease Prevention and control (CDC), Introduction to Program Evaluation for Public Health Programs : A Self-Study Guide2011; (October):[1-103 pp.].
38. Dennis F. et al. CDC Framework for Program Evaluation in Public Health. 1999;48(September):1-140.
39. J. M. Evaluating Public and Community Health Programs. first edition ed. USA: Jossey-Bass; 2010. 243 p.
40. BM foundation et al., Global Health Program: Family planning 2012 (April):1-4.
41. Abajobir A. Intention to use Long-acting and Permanent Family Planning Methods among Married 15-49 years Women in Debremarkos Town , Northwest. Fam Med Med Sci Res 2014;3(4):1-6.
42. Meskele M, et al. Factors affecting women ' s intention to use long acting and permanent contraceptive methods in Wolaita Zone , Southern Ethiopia : A cross-sectional study. BMC Women's Health. 2014;14(1):1-9.
43. Gebremariam A, et al. Knowledge and Perception on Long Acting and Permanent Contraceptive Methods in Adigrat Town , Tigray , Northern Ethiopia : A Qualitative Study. International journal of family medicine. 2014;2014(July):1-7.
44. Fikru T, et al. Quality of Family Planning Services in Primary Health Centers of Jimma Zone , Southwest Ethiopia. Ethiopia Journal of Health Science. 2013;23(3):245-54.
45. Asefa M. et. al., Assessment of quality of care in family planning services in Jimma Zone , Southwest Ethiopia. Ethiopia Jornal of Health Dev. 2003;18(1):8-18.
46. FMoH[Ethiopia], Family Planning Situation Analysis in Ethiopia. 2012 (November):1-4.
47. Bulto G, et al. Demand for long acting and permanent contraceptive methods and associated factors among married women of reproductive age group in Debre Markos Town , North West Ethiopia. BMC Women's Health. 2014;14(1):1-12.
48. Godana W, et al. Utilization of Long Acting and Permanent Family Planning Methods Among Womens Visiting Family Planning Clinic in Arba Minch Hospital. Journal of Health, Medicine and Nursing. 2015;15(5):62-71.

49. Hutchinson P, et al. Measuring client satisfaction and the quality of family planning services : A comparative analysis of public and private health facilities in Tanzania, Kenya and Ghana. BMC Health Services Research. 2011;11(1):1-17.
50. Argago T. et. a. Client ' s satisfaction with family planning services and associated factors among family planning users in Hlo,ssana Town Public Health Facilities , South Ethiopia : Facility-based cross-sectional study. International Journal of Nursing and Midwifery 2015;7(May):74-83.
51. Joseph S. Wholey et. al., Handbook Of Practical Program Evaluation. second edition ed. USA: Jossey-Bass; 2004. 768 p.
52. Baxter PJ, Susan. Qualitative Case Study Methodology : Study Design and Implementation for Novice Researchers Qualitative Case Study Methodology : Study Design and Implementation for Novice Researchers. The Qualitative Report,. 2008;13(4):544-59.
53. WHO, Toolkit on monitoring health systems strengthening service delivery. 2008 (June):1-18.
54. WHO, Tools for Assessing the Operationality of District Health Systems. 2003:1-112.
55. Measure Evaluation. Quick Investigation of Quality (QIQ) A User ' s Guide for Monitoring Quality of Care in Family Planning. Northern Carolina Measure Evaluation, 2001 Contract No.: 2.
56. CDC, Family planning methods and practice: Africa. 2nd edition ed. United States Department of Health and Human resource NCfcDCpaHP, Division of Reproductive Health, editor. Atlanta: Georgia 2000. 1-717 p.
57. Walle Tseganeh. Assessment of Quality of Family Planning Service , Bahar-Dar Special Zone , Amhara Regional State . 2005 (May):1-113.
58. Alemu Sufa Melka et. al., Determinants of long acting and permanent contraceptive methods utilization among married women of reproductive age groups in western Ethiopia: a cross-sectional study. Pan Africa Medical Journal available online at: (http://wwwpanafrican-med-journalcom/content/article/21/246/full/). 2015:1-10.
59. FMOH[Ethiopia]. Family Planning Situation Analysis in Ethiopia. 2012 (November):1-4.
60. Babalola S, and John., Factors Underlying the Use of Long-Acting and Permanent Family Planning Methods in Nigeria: A Qualitative Study. New York: EngenderHealth/The RESPOND Project.: Johns Hopkins Bloomberg School of Public Health Center for Communication Programs (JHU·CCP), 2016.
61. Elaine M., Best Practices in Client-Provider Interactions in Reproductive Health Services : A Review of the Literature: USAID Maximizing Access and Quality (MAQ) Initiative: available at: (www.MAQweb.org) accessed march, 2015[internet].
62. FMOH[Ethiopia], National Guideline For Family Planning 2011 (February):1-65.
63. FMOH[Ethiopia]. Family Planning: Blended Learning Module for the Health Extension Programme. 2010:1-152.
64. Mesganaw F. et. al., Quality of family planning services in Northwest Ethiopia. Ethiop Journal of Health Development 2005;3(19):195-202.
65. **Daniel L. Stufflebeam, Program evaluation Meta evaluation check list based on the program evaluation standard, 1999, p 1-11**

Annexes:

APPENDIX I: Tables for Judgment matrix

Table: Analysis and Judgment matrix for availability dimension of the evaluation of long acting family planning services at public health facility of Soro district Hadiya zone, Southern Ethiopia, 2016

Dimensions with indicators	Weight given	% Observed	Observed score	Judgment parameter
Availability (40%)				
Number of service providers who receive in-service training on long acting methods	12			[85 –100] -V. Good [75– 84] -Good [60-74] – Fair [< =59] – Poor
Proportion of HFs having basic instrument /equipment for provide long acting FP	15			
Proportion of HFs having all long acting FP contraceptives in accordance to	12			
Proportion of HFs having supplies for provide long acting FP	15			
Proportion of HFs having at least one FP guideline	12			
Proportion of HFs having separate FP room	8			
Proportion of HFs having IEC material for each service of long acting FP provided by HF	10			
Proportion of HFs experience stock out of long acting contraceptive for more than 30 days in the last consecutive 6 months	7			
Proportion of HFs having all recording & reporting formats (logbook, tall sheet, report sheet)	9			
Average scores of Availability (100%)				

Table: Analysis and Judgment matrix for compliance dimension of the evaluation of long acting FP services at public health facility of Soro district Hadiya zone, Southern Ethiopia, 2016

Dimensions with indicators	Agreed score	Observed score	%Weight	Judgment parameter
Compliance (35%)				
Proportion of client counseled on rapport building according to national guideline	10			[85 –100] -V. Good [85 –100] -V. Good [75– 84] -Good [60-74] – Fair [< =59] – Poor
Proportion of client counseled on exploration according to national guideline	10			
Proportion of clients made informed chose /decision	6			
Proportion of clients counseled on long acting FP by aid of at least one IEC materials	8			
Proportion of client got basic information on the method accepted (possibility of switching, side effects…)	10			
Proportion of client informed about the procedure (insertion & removal) of the selected method	6			
Proportion of LAFP service provision procedures followed infection prevention procedure according to national guideline	12			
Proportion of clients discuss on follow-up and revisits	10			
Proportion of client got instruction on wound care or check for IUCD in place(post insertion counseling)	9			
Proportion of HFs that follow consistence of recording and reporting the last 3 months performance	10			
Proportion of health facilities refer clients to next level using standard referral form	5			
Proportion of health facilities having follow up mechanism for tracing clients of LAFP	4			

Dimensions with indicators	Agreed score	Observed score	%Weight	Judgment parameter
Compliance (35%)				
Average scores of Compliance (100%)				

Table: Analysis and Judgment matrix for Accommodation dimension (satisfaction) of the evaluation of long acting FP services at public health facility of Hadiya zone, Southern Ethiopia, 2016

Dimensions with indicators	Agreed score	Observed score	%Weight	Judgment parameter
Satisfaction (Accommodation) (25%)				
Percent of client satisfied by the approach of service provider	5			[85 –100] -V. Good [75– 84] -Good [60-74] - Fair [< =59] - Poor
Percent of client perceive the availability of sufficient LARC methods	11			
Percent of client perceive the distance between home and SDP convenient	8			
Percent of client perceive that the counseling time is convenient	12			
Percent of client perceive waiting time at service delivery point is short	13			
Percent of client satisfied by privacy during counseling	12			
Percent of client satisfied by waiting area	10			
Percent of client satisfied on HFs having functional latrine & piped water	7			
Percent of client satisfied by cleanliness of the facility	8			
Percent of client satisfied with number of days LAFP services is available	7			
Percent of client satisfied by working hours of the facility	7			
Average scores of Satisfaction (100%)				

Table: Overall judgment matrix and analysis of long acting family planning services at public health facility of Soro district Hadiya zone, Southern Ethiopia, 2016

Dimension	Value weight	Present achieved	Value achieved	Judgment criteria

Availability	40%			**[85 –100] -V. Good**
Compliance	35%			**[70 – 84] -Good**
Accommodation	25%			**[55-69] - Fair**
Total score	**100%**			**[< =54] - Poor**

APPENDIX II: Tool to assess client satisfaction of long acting FP services

JIMMA UNIVERSITY

COLLEGE OF HEALTH SCIENCE

DEPARTMENT OF HEALTH ECONOMICS MANAGEMENT AND POLICY, HEALTH MONITORING AND EVALUATION UNIT

Client Exit Interview tool to Assess Client's Satisfaction on Long acting Family Planning Services at public health facilities

Region_____Zone_____Woreda_____Code no. of HFs_____

Good morning /Afternoon dear client! My name is _____. I came from Jimma University, College of Health Science, Department of Health Economics Management and Policy, Health Monitoring and Evaluation Unit. I am a member of evaluation research team on process evaluation of long acting family planning services in Soro district.

The purpose of this evaluation is to assess the implementation of long acting family planning service provided in some health institutions of Soro district and level of satisfaction of services users and finally to give important recommendations that will help to strengthen and improve the FP service in general and long acting FP in particular to meet the clients need or interest.

To do this, your information is very important. I would like to ask you a few questions about your visit to the clinic to find out your experience today. We would be very grateful if you could spend a less than 20 minutes to answer questions related to the service. We will not put your name

or registration number in the format. All the information you give will be kept strictly confidential. Your participation is voluntary and you are not obliged to answer any questions you don't want and you can stop interview at intervals if you are not comfortable with. By giving your response in this evaluation you can't get incentive but your honest participation will contribute to generate information that can be used to improve the implementation of the program of long acting family planning. **Do I have your permission to continue?** 1. Yes 2. No

If yes, Thanks for your cooperation!

Client visit 1. New Client ---------- 2. Repeat Client ----------

Code number of the client ---------- Arrival time at service delivery points--------

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

Interviewer:

Name_____ Cod number_____

Cheeked by supervisor /investigator Signature_____

Part I: Socio-demographic characteristics of respondent

S. N.	Questions & filter	Coding category	Skip to
101	How old are you?	1) ---------- old	
102	Place of residence	1) Rural 2) Urban	
103	What is your current marital status?	1) Single 2) Married & live together 3) Married but not live together 4) Divorced 5) Widowed	
104	If married /have regular partner, have you discussed family planning with your husband?	1) Yes 2) No	
105	Do you have children?	1) Yes 2) No ------ ---- -- →	Q 113
106	If yes, how many living children do you have?	1) 1-2 2) 3-4 3) 5+	
107	What is the age of your youngest child?	1) ------Year/Month------	
108	Would you like to have more children?	1) Yes 2) No 3) Depend on God 4) Depend on husband 99) No answer	
109	If yes, when would you like to	1) Immediately	

	have the next child?	2) Up to one year 3) Up to two years 4) Up to 3-5 years 5) After 5 years 99) No answer	
110	Are you currently breastfeeding?	1) Yes 2) No	
111	Family size?	_____	
112	What is your educational level?	1) Unable to read and write 2) Write & read only 3) Primary school(1-8) 4) Secondary school completed 5) Higher education	
113	Religion	1) Orthodox 2) Muslim 3) Protestant 4) Catholic 5) Others/specified----------	
114	Ethnicity	1) Hadiya 2) Kenbata 3) Gurage 4) Amhara 5) Others/specified----------	
115	What is your occupation?	1) Government employee 2) Private employee 3) Merchant 4) Un employed 5) House wife 6) Student 7) Daily laborer 8) Other (specify)----------	
116	What is your monthly income?	----------Eth. Birr (use annual income in kind & change to birr)	

Part II: Client interview on service satisfaction. (For both new and repeat)

S. N.	Questions & filter	Coding category	Skip to
201	Who told you for the first time about the family planning service of this health facility?	1. Husband 2. Neighbors 3. Health professional 4. Other (specify)_____	
202	How long did it take to you to arrive at this health facility?	1. Less than 1/2 hr. 2. 1/2 to 1 hr. 3. 1 to 2 hrs. 4. More than 2 hrs.	

		88. Don't know	
203	Is the distance between your home and health facility convenient to use the service?	1. Yes 2. No 88. Don't know	
204	Are the opening hours for this health facility convenient for you?	1. Yes 2. No 88. Don't know the opening hrs. 99. No answer	
205	How long did you wait between the time you first arrived to the clinic and gets service?	1. No wait 2. Less than 1/2 hr. 3. Half to one hour 4. 1 hour and above 88. Don't know	
206	How do you feel about your waiting time?	1. No waiting 2.Short 3.Long 4.Too long 88. Don't know	
207	Do you feel that today you received the information & service that you wanted?	1. Yes ----------→ 2.No 3.Some but not adequate information and service 4. I have received the service but not the information. 5. I have received the information but not the service. 6.Other (specify)----------	Qn. 209
208	If not why	1. Provider does not want to tell me 2.the service I want was not available 3.time was too short & I did not get time 4. Other (specify).----------	
209	How do you feel the consultation of the service provider?	1. About right 2.Too short 3.Too long 88. Don't know 99. No answer	
210	During consultation, was the provider easy to understand?	1.Easy to understand 2.Difficult to understand 3.Don't understand 99.No answer	
211	Did the provider encourage you to ask any questions that you concerned with?	1.Yes 2.No	
212	Did you ask any question about family planningwhy	1.Yes 2.No --- ----- ---------- ----- -→	

213	If yes, did the answer satisfy you?	1. Yes 2.No 3.Partically 99. No answer	Q214
214	Was there enough privacy during consultation?	1.Yes 2.No	
215	Did the service provider give you information about the whole procedure before providing the method?	1.Yes 2.No	
216	Do you recommend your relatives, friends and family about long acting family planning?	1.Yes 2.No	

Part II sections I: - Question for new family planning users

S.N.	Questions & filter	Coding category	Skip to
217	Why do you come to this health facility?	1. To start birth control 2. To get counseling 3. To get both service 4. other/specifies _____	
218	Did you decide to use long acting FP method at this visit?	1. Yes 2. No --- ---------- - ----- -→ 99. No answer	Q227
219	If yes which method did you accept today?	1) IUCD 2) Implanon 3) Jadelle 4) Sino 2 88. Don't know 99.No answer	
220	If no, why did you not start to use Long acting FP method today?	1.Change my mind 2.Came for information only 3.Pregnancey suspected 4.Contraindication for method wanted 5.Method wanted not available 88. Don't know 99. No answer	
221	Does the provider clearly explain the following issue about the method that you received?		
221.1	Explains how the method works?	1.Yes 2.No 88. Don't know 99. No answer	
221.2	Demonstrate how to use it?	1.Yes 2.No 88. Don't know 99. No answer	
221.3	Does the provider describe possible side effects?	1.Yes 2.No 88. Don't know 99. No answer	
221.3	Does the provider explain what to do	1.Yes 2.No	

	if you experience any problems before the next visit?	88. Don't know 99. No answer	
221.4	Does the provider explain the possibility of changing method if you are not happy with it?	1.Yes 2.No 88. Don't know 99. No answer	
221.5	Does the provider explain where to go for supply or follow up visit?	1.Yes 2.No 88. Don't know 99. No answer	
222	In addition to the method you received, did he/she told about any other methods?	1.Yes 2.No----------→ 88. Don't know 99. No answer	Q. 224
223	If yes, which method?		
223.1	Pills	1. Yes 2. No	
223.2	Injectable	1. Yes 2. No	
223.3	Spermicidal	1. Yes 2. No	
223.4	Diaphragm	1. Yes 2. No	
223.5	IUCD	1. Yes 2. No	
223.6	Condom	1. Yes 2. No	
223.7	Female sterilization	1. Yes 2. No	
223.8	Implanon	1. Yes 2. No	
223.9	Jadelle	1. Yes 2. No	
223.10	Other (specify)----------		
224	Will you come for next appointment?	1. Yes 2. No	

Part II Section II: for re-visit or follow-up clients

S.N.	Question and filter	Coding category	Skip to
225	Which method are you using?	1. IUCD 2. Implanon 3. Jadelle 4. Sino II 5. Other (specify)----------	
226	Which method do you know other than the method you are using?		
226.1	Pills	1. Yes 2. No	
226.2	Injectable	1. Yes 2. No	
226.3	Spermicides	1. Yes 2. No	
226.4	Diaphragm	1. Yes 2. No	
226.5	Condom	1. Yes 2. No	
226.6	IUCD	1. Yes 2. No	
226.7	Implanon	1. Yes 2. No	

226.8	Jadelle	1. Yes 2. No	
226.9	Sino 2	1. Yes 2. No	
226.10	Sterilization	1. Yes 2. No	
226.11	Other (specify) ----------		
227	Last time you have obtained long acting family planning, did you get it from this health facility?	1.Yes ---------- ------ ----------→ 2.No	Q. 229
228	If no, where did you get it	1.Other Governmental health institution 2.Private clinic 3.Community based distribution 4.Pharmacy 5.Other	
229	Did you pay for the service and for contraceptive?	1.Yes 2.No ------ ------ --- -----→	Q. 231
230	If yes how much for one visit?	1.Price for contraceptive per cycle---------- 2.Price for service ----------	
231	If a friend of yours wanted family planning service, would you encourage her to come to this clinic or go elsewhere?	1.Come to this clinic -- --- -- ---→ 2.Go to somewhere else 88. Don't know 99. No answer	Q. 233
232	If you encourage her to go somewhere else, why?		
232.1	Long waiting time here	1. Yes 2. No	
232.2	Far away	1. Yes 2. No	
232.3	Poor quality service here	1. Yes 2. No	
232.4	Poor/inadequate consultation here	1. Yes 2. No	
232.5	Only few family planning methods are available here	1. Yes 2. No	
232.6	No answer	99. No answer	
232.7	Other (specify)----------		
233	Which service did you like from this clinic?		
233.1	Get service with in short period	1. Yes 2. No	
233.2	Provider gives good service	1. Yes 2. No	
233.3	Counseling was clear & satisfactory	1. Yes 2. No	
233.4	Received the method chosen	1. Yes 2. No	
233.5	No answer	99. No answer	
233.6	Other (specify)----------		

234	Will you come for next appointment?	1. Yes 2. No	

Part III: User specific interview questioners for service utilized

Part III: Section I: for IUCD inserted women

No	Question and filter	Coding category	Skip to
235	If intrauterine contraceptive device is inserted, can you tell me how you check it is in place?	1.Touching the thread regularity 2.It cannot slip out once it is inserted 3.Other (specify)---------- 88. Don't know	
236	When do you come back for first checkup?	1- No need to come back 2- Less than a month 3- After one month 4- After one year 88- Don't know	
237	Have you told the importance of this method?	1-Yes 2- No 99. Don't remember	
238	What are the minor problems, if any, you may experience with having an intrauterine contraceptive device?		
238.1	No problems	1. Yes 2. No	
238.2	Spotting b/n Menstrual periods	1. Yes 2. No	
238.3	Increased discharge	1. Yes 2. No	
238.4	Infection	1. Yes 2. No	
238.5	Don't know	99.	
238.6	Other /Specify/ ----------		
239	Apart from the regular check - up visit for what problems, will you return to the clinic?		
239.1	No problem	1. Yes 2. No	
239.2	Heavy discharge	1. Yes 2. No	
239.3	Expulsion or cannot feel threads	1. Yes 2. No	
239.4	Abdominal pain or sever cramps	1. Yes 2. No	
239.5	Pain during intercourse	1. Yes 2. No	
239.6	Fever, chills	1. Yes 2. No	
239.7	Don't know	99	
239.8	Other (Specify)----------		
240	Do you know how long can intrauterine	1- Number of Years----------	

	device serve once it has been inserted?	99. Don't know	
241	Will you continue this method?	1. Yes 2. No	

2) For Implanon/Jadelle users (underline the type of method)

No	**Question and filter**	Coding category	Skip to
242	How often can you change Implanon/Jadelle?	1- Every 7 years 2- Every 5 years 3- Every 3 years 4- Every 3 months 88- Don't know	
243	Do you told the importance of Implanon/Jadelle?	1- Yes 2- No 99. don't remember	
244	What are the minor problems, if any, you may experience with having an insertion of Implanon/Jadelle?		
244.1	No problems	1. Yes 2. No	
244.2	Increased discharge	1. Yes 2. No	
244.3	Weight gain	1. Yes 2. No	
244.4	Headache	1. Yes 2. No	
244.5	Don't know	99	
244.6	Other /Specify/ ----------		
245	Did the service provider tell you when to come back?	1- Yes 2- No	
246	Apart from the regular visit, for what problems, if any, should you come back to the clinic?		
246.1	No problem	1. Yes 2. No	
246.2	Infection at the insertion site(pain, heat, pus, or redness)	1. Yes 2. No	
246.3	Heavy vaginal bleeding	1. Yes 2. No	
246.4	Severe headache	1. Yes 2. No	
246.5	Unexpected weight gain	1. Yes 2. No	
246.6	Don't know	99	
246.7	Other/Specify/----------		
247	Will you continue this method?	1. Yes 2. No	

Part IV. Miscellaneous level on client satisfaction

INSTRUCTION: The following statements are about different characteristics that client satisfies. Please mark (√) according to your agreement in the statement, i.e., if they strongly not satisfied and not satisfied mark(√) respectively, if they are in between not satisfied and agree mark (√) at neutral and if they are not satisfied and strongly not satisfied mark(√) on the space provided respectively.

No	Statement	1 Strongly not satisfied	2 Not satisfied	3 Neutral	4 Agree	5 Strongly agree
248	The approach of service provider?					
249	Sufficient methods LAFP available?					
250	Waiting time at SDP is adequate?					
251	Distance to home HF convenient?					
252	Privacy was maintained?					
253	Waiting area suitable?					
254	Consultation time adequate?					
255	Availability of functional latrine with pipe water supply?					
256	Cleanliness of the facility?					
257	Numbers of day's services are available to you?					
258	Hours of service at this facility?					

Thank you very much!

APPENDIX III: Tool for observation of compliance

Code number of the health institution_____

INSTRUCTIONS TO OBSERVER**:** When a family planning client arrives at the health facility, Greet client; introduce yourself and the purpose of the study, ask the willingness to let you observe the visit and to answer a few questions afterwards about the services she has received. It is essential that you gain her informed consent before beginning the observation, so the following consent should be given & after reading sign and date the statement that the client agreed to participate. Obtain the agreement of both client and provider before proceeding to observe the interaction between them. No need of intervention to be involved. For each of the question listed below, tick that represents your observation of what happened during observation.

Good morning/afternoon dear provider!

Hello. My name is _____ I am a member of Jimma University research team. We are conducting evaluation research on long acting family planning in Soro district. The health facility has given us permission to do this assessment. The information from the assessment will be used to improve the services in this and other health facilities of Soro district. I would like to observe your consultation with this client in order to find out how long acting FP services provided at this health facility. Your participation is extremely important, but it is entirely voluntary. Don't worry about information confidentiality, neither your name and nor that of the client will be stated. If at any point you are not confortable you can ask me to leave.

Do I have a permission to present at this consultation? Yes_____ No_____(END)

Good morning/afternoon dear client!

Hello. My name is _____ I am a health professional and member of Jimma University research team. We are doing evaluation research on long acting family planning in Soro

district to find out about the services provided at this health facility. The information from the assessment will be used to improve the services in this and other health facilities of Soro district. The health facility has given us permission to do this assessment and we are asking all long acting family planning clients who visit the clinic today to be participating. We would like your permission to observe your visit with the health facility staff and to ask you a few questions about the visit afterwards.

Your participation is extremely important, but it is entirely voluntary. You do not have to be observed, nor do you have to answer any questions if you do not want to. You will not be denied any services if you decide not to participate. I will not write down your name and everything you tell me will be kept strictly confidential. During your visit, I will be sitting a little apart from you and the clinic staff. After consultation we will talk about your experience here today.

Do I have your permission to be present in this consultation? Yes_____ No_____

If **Yes,** ask the client to put a sign and date the statement below and continue with the observation.

I certify that I heard/read the statement (consent) above and I am agreed to participate in the study.

Client signed_____ Date_____

Code number of the client _____, Date of visit observation began end _____.

Time taken for consultation _____ Total time required _____

Name of observer_____ signature_____

Checked by supervisor/investigator_____ Signature_____

Provider category/profession and qualification/_____

Sex of provider Female _____ Male_____

Part I: Counseling observation checklist for long acting family planning clients

300. Visit of client for long acting family planning service?

New_____ Return_____

Time counseling started _____:_____

Instruction: if the client visited the clinic for the first time (new clients) follow section one and for clients who visit the clinic for more than one time (return visited) follow section two of the part one

Part I section I: Counseling observation checklist for new client and re-visit client who switch other/not the usual/ long acting family planning

S. N.	Did the provider	Coding category	Skip to
301	Rapport building		
301.1	Does provider greet client and offer seat?	1- Yes 2- No	
301.2	Make introduction?	1- Yes 2- No	
301.3	Assure privacy?	1- Yes 2- No	
302	Ask for the reason for the visit?	1- Yes 2- No	
303	Explore client knowledge, intention and concern about FP and give additional explanation?	1- Yes 2- No	
304	Ask reproductive history and fertility plan?	1- Yes 2- No	
305	Ask if the client has a particular family planning method in mind?	1- Yes 2- No	
306	Does client has inclination for a particular Method?	1- Yes 2- No	
307	Provide information about family planning choices?	1-Yes 2-No	
308	During consultation, did the provider talk about any of the following?		
308.1	Pills	1-Yes 2-No	
308.2	Spermicide	1-Yes 2-No	
308.3	Condom(male & female)	1-Yes 2-No	
308.4	Injectable	1-Yes 2-No	
308.5	Sino II implant	1-Yes 2-No	
308.6	IUCD	1-Yes 2-No	
308.7	Implanon	1-Yes 2-No	
308.8	Jadelle	1-Yes 2-No	
308.9	Sterilization	1-Yes 2-No	
308.10	Other/specified----------	1-Yes 2-No	
309	Did the provider promote or overemphasize one method in particular?	1- Yes 2- No -- ---- ---- -- --→	**Q. 311**
310	If yes, which method	1. Pills 2. Injectable 3. Condom 4. Spermicidal 5. Diaphragm 6. Implanon 7. Jadelle 8. Sino II 9. IUCD 10. Sterilization 11. Other/specify-----	
311	Did the provider utilize IEC materials during consultation?	1- Yes 2- No--- ---- -- --→	**Q.313**

312	Which type of IEC materials used during consultation:-		
312.1	Flip chart	1- Yes 2- No	
312.2	Brochure/pamphlets	1- Yes 2. No	
312.3	Sample of contraceptive	1- Yes 2- No	
312.4	Posters	1- Yes 2- No	
312.5	Anatomical model	1- Yes 2- No	
312.6	Other (Specify)----------	1- Yes 2- No	
313	Did the provider help the client to make an informed choice?	1- Yes 2- No	
314	Provide accurate information on the method accepted (how to use, side effects, advantage & disadvantage)	1- Yes 2- No	
314.1	How the method works	1- Yes 2- No	
314.2	Advantage and disadvantage of the method	1- Yes 2- No	
314.3	The side effects of the method	1- Yes 2- No	
315	Explain method does not protect against STIs and AIDS?	1- Yes 2- No	
316	Explain how the procedure will be performed the method accepted?	1- Yes 2- No	

Time observation Session End _____:_____

Part I section II: Counseling observation checklist for re-visit clients of long acting family planning

S. N.	**Did the provider**	**Coding category**	**N/A**
321	**Establish rapport**	1- Yes 2- No	
321.1	Does provider greet client and offer seat?	1- Yes 2- No	
321.2	Make introduction	1- Yes 2- No	
321.3	Assure confidentiality & privacy	1- Yes 2- No	
322	Ask for the reason for the visit?	1- Yes 2- No	
323	Ask the satisfaction with the current method?	1- Yes 2- No	
324	If there is not satisfied with the current method, did explore the reason and set possible solutions?	1- Yes 2- No	
325	Confirm method used?	1- Yes 2- No	
326	Ask any circumstance that the client face and discussed?	1- Yes 2- No	
327	Ask the client identify what service needed during this return visit (resupply, follow up)	1-Yes 2-No	
328	Help the client in implement the decision (continue the current method, switch other method, discontinue the method)	1-Yes 2-No	
329	Make follow up plan if applicable	1-Yes 2-No	

330	Did the client switch other method from the usual of long acting FP?	1-Yes ----------→ 2-No	**Part I section I**
331	Register information on the visited date & appointment on logbook?		
332	Put tally mark on the service provision tally sheet		
333	Records contraceptive supplies/dispensed on FP dispensed tally sheet		

Time observation Session end _____:_____

Part II. Observation checklist to clinical procedures of long acting family planning clients

340. Did the provider trained on the method provided? 1. Yes 2. No

341. Did the clinical provider same person who provided counseling? 1. Yes 2. No

342. If different person: provider category/profession and qualification/_____

Time observation Session began _____:_____

Part II: Medical history and physical examination

No	Question and filter	Yes	No	N/A
343	**During consultation, did the provider ask (assess) the client on the following?**			
343.1	About contraceptive method history			
343.2	About date of LMP			
343.3	Unusual vaginal discharge/bleeding			
343.4	Pelvic pain			
344	Take weight			
345	Take blood pressure			
346	Assess symptoms of STI			
347	Did laboratory test			
348	Perform Physical examination			

Part III: Clinical procedure

Instruction: Follow the procedure based on the information provided in the table with the indicated methods of choice and the procedure the service provider followed.

Observation conducted for:	**Yes**	**No**
1. Client underwent pelvic exams – if yes, complete section I		
2. Client chose an Implanon or Jadelle inserted and removed – if yes, complete section II		

3. Client chose an IUD inserted and removed – if yes, complete section III		

Part III Section I: Pelvic Examination

S.N.	During pelvic Examination: provider did	Yes	No	N/A
P1	Reconfirm the client choice of method			
P2	Ensure client has privacy			
P3	Explain the procedure follow			
P4	Prepare all instruments before exam			
P5	Use sterilized or high-level disinfected instruments for each exam			
P6	Wash hands before exam			
P7	Put on new or disinfected gloves before exam			
P8	Inspect the external genitalia			
P9	Ask the client to take slow, deep breaths, and relax all muscles			
P10	Inspect the cervix and vaginal mucosa			
P11	Perform bimanual exam gently and without discomfort to client			
P12	Client informed about outcome/result of exam?			
P13	Ensure that instruments and reusable gloves are decontaminated			

Part III Section II: Implant (Implanon or Jadelle) insertion and removal

S.N.	During Implant (implanon or Jadelle) inserted and remove the provider did	Yes	No	N/A
IJ 1	Reconfirm the client choice of method			
IJ 2	Ensure privacy before procedure			
IJ 3	Explain the procedure follow			
IJ 4	Prepare all instrument before the procedure			
IJ 5	Use sterilized or high-level disinfected instruments			
IJ 6	Locate the incision site by marker/pen using ruler (insertion) or palpation (removal)			
IJ 7	Wash hands before procedure			
IJ 8	Put on new or disinfected gloves before exam			
IJ 9	Cleaned the skin where incision was made with antiseptics?			
IJ 10	Use sterile/new towel/ to protect the area?			
IJ 11	Use new needle and syringe for local anesthetic?			
IJ 12	Allow a time for local anesthetic to take effect prior to incision?			
IJ 13	Use of mosquito forceps for removal			

IJ 14	Use of Crile forceps for removal			
IJ 15	Ensure that instruments and reusable gloves are decontaminated?			
IJ 16	Wash hands after procedure			
IJ 17	Ask client to wait/rest for at least 15 minutes after insertion and removal?			
IJ 18	Instruct client regarding (wound care and return visit)			

Part III Section III: Intra uterine Contraceptive Device (IUCD)

S.N.	**During Intra uterine Contraceptive Device (IUCD) inserted or removed: provider did**	**Yes**	**No**	**N/A**
IU 1	Reconfirm client's method choice			
IU 2	Ensure client has privacy			
IU 3	Prepare all instrument before the procedure			
IU 4	Use sterilized or high-level disinfected instruments			
IU 5	Wash hands before putting on gloves			
IU 6	Conduct speculum exam for RTI/STIs before bimanual exam			
IU 7	Conduct bimanual pelvic exam			
IU 8	Clean cervix with antiseptics			
IU 9	Use tenaculum			
IU 10	Sound the uterus before IUD insertion			
IU 11	Use the no-touch technique for inserting the IUD			
IU 12	Wash hands after removing gloves			
IU 13	Emotional support given for Client?			
IU 14	Ask client to wait/rest for at least 15 minutes after insertion and removal			
IU 15	Give post insertion/removal instructions (how to check IUCD in a place, return visit)?			
IU 16	Wipe contaminated surfaces with disinfectant			
IU 17	Ensure that instruments and reusable gloves are decontaminated			

Time observation Session End _____:_____

This is the end. Thank you!

Appendix IV: Tool for key informant interview

Code of the health institution_____

Hello. My name is _____ I am a member of Jimma University research team. We are conducting evaluation research on long acting family planning in Soro district. The information from the assessment will be used to improve the services in this and other health facilities of Soro district. I would like to ask you some questions to get information from your experience on the service and this health facility. To do this, your information is very important. I would like to ask you a few questions about this health facility. We would be very grateful if you could spend a less than 20 minutes to answer questions related to the service. Your participation is extremely important, but it is entirely voluntary and you are not obliged to answer any questions you don't want and you can stop interview at intervals if you are not comfortable with. By giving your response in this evaluation you can't get incentive but your honest participation will contribute to generate information that can be used to improve the implementation of the program of long acting family planning. Don't worry about information confidentiality, both your name and your institution name will not be stated.

May I continue? Yes--------- No ----------

Thank you!

Code of health facility_____ Cod of the service provider_____

Sex ___ Age _____ Educational status and profession _____

Experience in Providing Family Planning, Including LARC

1. How long have you been working here? _____
2. For how long have you been providing family planning service? ____
3. What kind of training on family planning have you ever attended? /on Job training/
4. Do you think that the training you have received in FP is adequate to perform your duties?
5. Which of the contraceptive methods are provided at this facility? Type of contraceptive? Usually provided methods? Available today?
6. What is the common family planning method requested by clients in this facility? Why are the methods preferred?
7. What is the importance of availability of long acting FP services?
8. How common do family planning clients request for long acting here?
9. For clients who report discontinuation of use of a method or long acting, what were the common reasons given for discontinuation?
10. What could be some of the reasons why clients would avoid using Long acting FP?
11. What are the challenges in providing Long acting FP here?
12. What do you think should be done to improve family planning service provision especially the LAPM provision?
13. What do you think should be done to encourage uptake of LAPM among women?
14. If a client would like a method that is not available at your health facility, what would you say to her?
15. Which method of FP would you recommend for most people who would like to delay or space their next birth? Why? ----------
16. Which method never you recommend? Why? ----------

B- Suggestions for improving family planning services

1. In your opinion which methods of long acting family planning should be given priority and should be improved?
2. In your opinion, do you believe that there are adequate teaching aids for family planning clients coming to your institutions?
   2.1. Is there a method to follow up defaulters among family planning clients?

2.2. If yes, which method of follow up are you using?

2.3. If a family planning client has a problem, which is beyond the capacity of the institution or if the method the client desired is not available in the institution, is there a method of referring her to a better health institution?

2.4. If yes, do you have a copy left here? And was feedback sent to you?

Part V: Assessment tool for General Health Facility condition for rendering long acting FP program

5.1. What is the official opening time for this Service delivery point?

5.2. How soon after the official opening time were services provided?

5.3. How many health care providers are assigned for family planning service? Which qualifications?

5.4. How many of them were got on job training on Long acting FP? Numbers with type of Long acting FP methods they have got on job training?

5.5. Is there guideline for long acting family planning? Numbers with type of Long acting FP? Date of publication?

5.6. Are family planning services being provided on the day of the visit?

5.7. Is there a sign announcing that family planning/LAPM services are available?

5.8. Indicate the number of staff who provides family planning service at this service delivery point on the day of the visit, within each designation (eg, nurse, Dr----)

5.9. Was daily based health information provided at this health facility? Yes for the last consecutive 6 months? was the topic include family planning including Long acting FP? Who was educating (qualification)? Do they use IEC/BCC materials?

5.10. Is there a separate room or area for physical examination?

5.11. How was the condition of the examination room?

5.12. Is adequate light and water available in the examination room?

5.13. Is there a record system for keeping track of family planning commodities received and dispensed?

5.14. Is the HFs stock out long acting supplies for more than 30 days the last consecutive 6 months? Which contraceptive?

5.15. Are family planning commodities stored according to their expiration date?

5.16. Are storage facilities for contraceptives appropriate? ("Appropriate" means no exposure to rain and sun, protected from rats and pests. And not subjected to extreme heat)

APPENDIX V: Resource inventory tool**:**

To assess the availability of resource to provide Long acting and Permanent Family Planning Services in health facilities

JIMMA UNIVERSITY

COLLEGE OF HEALTH SCIENCE

DEPARTMENT OF HEALTH ECONOMICS MANAGEMENT AND POLICY, HEALTH MONITORING AND EVALUATION UNIT

Resource inventory tool: To Assess the availability of resource to provide Long acting Family Planning Services in Public Health Facilities

Facility Audit

Instruction: Complete this inventory by using observation and discussion with the person in charge of family planning service on the day of the visit. Verify the existence of functional equipment and supplies and also the general condition of the facility through observation. If you can't observe the equipment supplies and conditions, then indicate this in the margins. **Remember:** that the objective is to identify the equipment and facilities that currently exist for the service and not to evaluate the performance of the staff or health institution. **Note:** the respondent should be the manager/person in charge of knowing long acting FP department situation.

Thank You!

Part 1: Background characteristics

Health institution Name		
Code of health institution		
Date of inventory		
Name & signature of data collector		

Part II: Assessment tool for availability of equipment for rendering long acting FP program

S. N.	Type of equipment and supplies	Available Quantity	Functionality		Not available		Stock out	
			Yes	No	Not at all	Stock out	<30 days	>30 days
001	Flash light							
002	Cup, bowl, or gallipot							
003	Scalpel handle with blade							
004	Sterile surgical drapes							
005	Holding forceps (5.5" or 14 cm)							
006	Mosquito forceps (5" or 12.5 cm, curved, delicate)							
007	5 ml syringe with needle							
008	Sharp trocars/if the method package not have							
009	Sterile gauze							
010	Skin bandage or Band-Aid							
011	Implanon contraceptive							
012	Jadelle contraceptive							
013	Uterine sound							
014	Speculum							
015	Mayo Scissors							
016	Tenaculum							
017	Pregnancy test							
018	Antiseptic solutions (Iodine or chlohexidine)							
019	Lidocaine							
020	Sterilizer							
021	Sterile gloves							
022	Disposable gloves							
023	Disposable needles and syringes							
024	Disposable containers for contaminated waste							
025	Sharp containers for used sharps /safety box/							
026	Clean instrument container							

S. N.	Type of equipment and supplies	Available Quantity	Functionality		Not available		Stock out	
			Yes	No	Not at all	Stock out	<30 days	>30 days
027	Instrument trays							
028	Examination couch or table							
029	IUCD contraceptive							
030	Other (specify)----------							

Part III: Assessment tool for availability of amenities for rendering long acting FP program

Available amenities					
S.N	Amenities	Available	Functional		Not-available
			Yes	Not	
50	Electricity				
51	Water				
52	Working toilet				
53	Telephone				
54	Waiting area for clients				
55	Examination room				
56	Table and seat for service provided				
57	Water for hand-washing				
58	Soap				
59	Single use towel				
60	Decontamination solution				
61	Privacy in exam room/screen				

Part IV: IEC/BCC Material and activity

4.1. Is there a sign on the wall of the building on the wall announcing that service availability of family planning? 1. Yes 2. No

4. 2. Which family planning IEC material available? (Observe and ask)

S. N	IEC/BCC material	Short term	IUCD	Implanon	Jadelle	Sterilization	
						male	female
1	Posters						
2	Flip chart						

3	Brochure/pamphlet						
4	Anatomical model						
5	Information sheet						
6	Job aids						
7	Other specified_____						

APPENDIX VI: Document review tool

Part I: Record keeping and reporting

1. Is there a client record card for recording multiple visits or new card issued for each visit?
2. In what condition is the record-card system?
3. Is there a daily family planning activity register /logbook?
4. Is there a daily family planning activity tally sheet?
5. Is there registered that family planning dispensed tally sheet?
6. Is there referral form for services beyond HFs capacity and services that are not rendered by them?
7. Is the HF having an outreach schedule for Long acting FP (at least twice for the last 6 months)?
8. Is there Long acting FP plan performance for the past six month?
9. Are monthly statistical reports about Long acting FP activity sent to a supervisor or higher unit?
10. When was the last report sent? Is feedback received on reports? Is there copy of a report for the last 6 months? Availability of report format for the previous 2 months?
11. Is there performance monitoring mechanism for long acting FP? (see minute and of action plan)
12. When was the last time a supervisor come here from higher unit in relation to family planning?

Part II: Record keeping and reporting

S.N	**Long acting FP**	**Monthly performance**		
		_____Month	**_____Month**	**_____Month**

	methods	logbook	tally	report	Diff.	logbook	tally	report	Diff.	logbook	tally	report	Diff.
1	**Implanon**												
2	**Jadelle**												
3	**Sino II**												
4	**IUCD**												
	LARC												

- End -

APPENDIX VII: Sample Amharic questionnaire for exit interview

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}.l	ØÁo" T×]Á	¾SMe ›T^ß" SKÁ	¢É lØ` Ã²KM

201	Ÿ²=I ¡K='>¡ ¾[ÏU Ó²? ¾u?}cw U×'@ ›ÑMÓKAƒ A"ÅT>cØ SËS]Á T"'Ñ[-ƒ;	1. vKu?, 2. ÑA[u?„Š 3. ¾Ö?" vKS<Á 4. K?L /ÃÑKê/ ----------	
202	Ÿu?ƒ- A²=I Ö?" É`Ïƒ KSÉ[e U" ÁQM Ñ>²? ÃÚ`ew-ªM;	1. ŸÓTi c¯ƒ uª‹ 2. ŸÓTi • AeŸ ›"É c¯ƒ 3. Ÿ›"É AeŸ G<Kƒ c¯ƒ 4. ŸG<Kƒ c¯ƒ uLÃ 88. ›L¨<k¨<U	
203	Ÿu?ƒ- AeŸ²=I Ö?" É`Ïƒ ÁK¨< `kƒ ›ÑMÓKA~" KTÓ–ƒ ÃeTT-ªM;	1. ›- 2. ¾KU /›MeTU 88. ›L¨<k¨<U	
204	¡K='>Ÿ< ¾T>Ÿðƒuƒ" ¾Y^ c¯ƒ ÃeTT-ªM;	1. ›- 2. ¾KU /›MeTU 88. ›L¨<k¨<U 99. SMe ›M}cÖuƒU	
205	A²=I ¡K='>¡ ŸÅ[c<uƒ c¯ƒ ËUa ›ÑMÓKAƒ AeŸ›Ñ–<uƒ U" ÁQM Ñ>²? q¿;	1. U"U qÃª ¾KU 2. ŸÓTi c¯ƒ Á'c 3. ŸÓTi • eŸ ›"É c¯ƒ 4. Ÿ›"É c¯ƒ uLÃ 88. ›L¨<k¨<U	
206	K›ÑMÓKAƒ eKq¿uƒ Ñ>²? U" ÃcT-ªM;	1. U"U qÃ• ¾KU 2. ›ß` Ñ>²? '¨< 3. [ÏU Ñ>²? '¨< 4. u×U [ÏU Ñ>²? '¨< 88. ›L¨<k¨<U	
207	u³_¨< AKƒ ¾T>ðMÑ<ƒ" S[Í" ›ÑMÓKAƒ ›Ó˜‰KG< ¾T>M eT@ƒ ›K-ƒ;	1. ›- 2. ¾KU 3. ›ÑMÓKA~"" S[Í¨<" uSÖ'< ›Ó˜‰KG< 4. ›ÑMÓKA~" ›Ó˜‰KG< S[Í Ó" um ›ÃÅKU 5. um S[Í ›Ó˜‰KG< ›ÑMÓKAƒ Ó" ›LÑ–<G<U 6. K?L /ÃÑKê/----------	¨Å ØÁo 209 Ã²a¨`
208	ŸLÑ–< ª"¨< U¡"Áƒ U" ÃSeM-M;	1. ›ÑMÓKAƒ cß¨< õLÑAƒ eKK?¨< 2. ¾UðMÑ¨< ›ÑMÓKAƒ vKS•\ 3. Ñ>²?¨< ›ß` uSJ'< 4. K?L /ÃÑKê/ ----------	

209	ŸvKS<Á¨< Ò` KS'ÒÑ` ¾'u[¨< Ñ>²? um 'u` ¾T>M eT@ƒ ›K-ƒ;	1. Ñ>²?¨< um 'u` 2. u×U ›ß` Ñ>²? 'u` 3. u×U [ÏU 'u` 88. ›L¨<pU 99. SMe ›M}cÖuƒU	
210	uU¡` ›ÑMÓKAƒ Ñ>²? ¾U¡` ›ÑMÓKAƒ cß¨<" ukLK< S[Çƒ Ã‰LM;	1. ukLK< S[Çƒ Ã‰LM 2. KS[Çƒ ›e†Ò] 'u` 3. S[Çƒ ›Ã‰MU 99. SMe ›M}cÖuƒU	
211	K›ÑMÓKAƒ cß¨< ØÁo "M-ƒ A"Ç=Áp`u< U‡ G<'@ª" ðØa 'u`;	1. ›- 2. ¾KU	
212	eK u?}cw U×'@ K›ÑMÓKAƒ cß¨< ØÁo ›p`u¨< 'u`;	1. ›- 2. ¾KU---------- $	¨Å 214 ¾}²ª¨[
213	SMc< ›- ŸJ' u}cÖ- SMe [¡}¨<bªL;	1. ›- 2. ¾KU 3. uŸòM 99. SMe ›M}cÖuƒU	
214	uU¡` ›ÑMÓKAƒ Ñ>²? Kw‰-" ›S‹ G<'@ª• }ðØaKAƒ 'u`;	1. ›- 2. ¾KU	
215	›ÑMÓKAƒ cÜ¨< vKS<Á ¾¨cÆƒ" ¾u?}cw U×'@ ŸSeÖ~ uòƒ ›ÖnLÃ S[Í }cØƒ-}M;	1. ›- 2. ¾KU	
216	uT>kØK¨< kÖa- ÃSKdK<;	1. ›- 2. ¾KU/›MSKeU	

¡õM 2."/¡õM 1:- K›Ç=e u?}cw U×'@ }ÖnT>-‹ ¾T>k`w SÖÃp:

}.l	ØÁo" T×]Á	¾SMe ›T^ß" SKÁ	¢É lØ` Ã²KM
217	¨Å²=I Ö?" É`Ïƒ KU" SÖ<;	1. ¾¨K=É Sq×Ö]Á KS¨<cÉ 2. ¾U¡` ›ÑMÓKAƒ KTÓ–ƒ w‰ 3. G<K~"U ›ÑMÓKAƒ KTÓ–ƒ 4. K?L/ÃÖke----------	
218	›G<" ¾[ÏU Ó²? ¾¨K=É Sq×Ö]Á KS¨<cÉ ¨e'ªM;	1. ›- 2. ¾KU ----------$	¨Å 220 ¾µ[
219	SMc< ›- ŸJ' ¾ƒ—¨<" ²È '¨< S[Ö<ƒ;	1. uTQì" ¾T>kSØ 2. ›=UøL•M u¡"É LÃ ¾T>ku` 3. ËÉM u¡"É LÃ ¾T>ku` 4. c=• u¡"É LÃ ¾T>ku` 5. K?L /ÃÑKê/----------	

220	SMc< ¾KU ŸJ' KU" ¾¨K=É SŸLŸÁ ²È SÖkU ›MðKÑ<U;	1. HXu?" uSk¾_ 2. S[Í w‰ KTÓ–ƒ eKS×G 3. • `Ó´" Ø`×_ eLK 4. ¾UðMÑ¨< ¾¨K=É Sq×Ö]Á ²È • A'@ M¨eÅ¨< ¾TM‹M SJ'< eK}'Ñ[˜ 5. ¾ðKŸ<ƒ ¾Sq×Ö]Á ²È vKS•\ 88. ›L¨<pU 99. SMe ›M}cÖuƒU	
221	• A`e- eKT>¨eÆƒ ¾¨K=É SŸKŸÁ ²È ¾U¡` ›ÑMÓKAƒ cÜ¨< eKT>Ÿ}K<ƒ 'Øx‹ um ÑKí ›Å[ÑK-ƒ;		
221.1	¾¨K=É SŸLŸÁ ²È¨< A"Èƒ A"ÅT>c^ 'Ñ[-ƒ;	1. ›- 2. ¾KU 88. ›L¨<pU 99. SMe ›M}cÖƒU	
221.2	ANÈƒ • A"ÅT>ÖkS< ›XÃ„¿ªM;	1. ›- 2. ¾KU 88. ›L¨<pU 99. SMe ›M}cÖƒU	
221.3	eKT>›S×¨< Ö"p }'Óa¿ªM;	1. ›- 2. ¾KU 88. ›L¨<pU 99. SMe ›M}cÖƒU	
221.3	‹Ó` u=ÁÒØU- ¾kÖa- k" ŸSÉ[c< uòƒ SU×ƒ A"ÇKw-ƒ }'Óa¿ªM;	1. ›- 2. ¾KU 88. ›L¨<pU 99. SMe ›M}cÖƒU	
221.4	¾SŸLŸÁ ²È¨< "M}eTT-ƒ K=kÃ\ A"ÅT>‹K< }'Óa¿ªM;	1. ›- 2. ¾KU 88. ›L¨<pU 99. SMe ›M}cÖƒU	
221.5	KT>kØK¨< kÖa- ¾ƒ SH@É AÇKw-ƒ }'Óa¿ªM;	1. ›- 2. ¾KU 88. ›L¨<pU 99. SMe ›M}cÖƒU	
222	›G<" K=ÖkS<uƒ Ÿ}kuK<ƒ ¾¨K=É SŸLŸÁ K?L ¾¨K=É SŸLŸÁ ²È A"ÇK }'Óa¿ªM;	1. ›- 2. ¾KU 88. ›L¨<pU 99. SMe ›M}cÖƒU	
223	Ÿ}'Ñ[-ƒ ¾ƒ—¨< ¾SŸLŸÁ ²È '¨<;		
223.1	¡'>"	1. ›- 2. ¾KU	
223.2	S`ô	1. ›- 2. ¾KU	
223.3	ì[¨"É ¾²` õ_	1. ›- 2. ¾KU	
223.4	¾TIì" qw	1. ›- 2. ¾KU	
223.5	uTQì" ¾T>kSØ	1. ›- 2. ¾KU	

223.6	¢"ÅU	1. ›- 2. ¾KU	
223.7	TQì" SsÖ`	1. ›- 2. ¾KU	
223.8	›=UøL•M u¡"É ¾T>ku`	1. ›- 2. ¾KU	
223.9	ËÉM u¡"É ¾T>ku`	1. ›- 2. ¾KU	
223.10	K?L/ ÃÑKê/----------		
224	uT>kØK¨< kÖa ÃSKdK<;	1. ›- 2. ¾KU	

¡õM 2 "/¡õM 2:- K}SLLi }ÖnT>-‹ ¾T>k`w SÖÃp

}.l	ØÁo" T×]Á	¾SMe ›T^ß" SKÁ	lØ` Ã²KM
225	¾ƒ—¨<" ¾SŸLŸÁ ²È '¨< ¾T>ÖkS<;	1. uTQì" ¾T>kSØ(K<ý) 2. ›=UøL•M u¡"É ¾T>ku` 3. ËÉM u¡"É ¾T>ku` 4. c=• u¡"É ¾T>ku` 5. K?L /ÃÑKê/ ----------	
226	›G<" ŸT>ÖkS<uƒ ¾¨K=É SŸLŸÁ K?L ¾ƒ—¨<" ²È Á¨<nK<;		
226.1	¡'>"	1.›- 2. ¾KU	
226.2	S`ô	1.›- 2. ¾KU	
226.3	ì[¨"É ²` (ðdi pvƒ	1.›- 2. ¾KU	
226.4	¾TQì" qw	1.›- 2. ¾KU	
226.5	¢"ÊU	1.›- 2. ¾KU	
226.6	uTQì" ¾T>kSØ (K<ý)	1.›- 2. ¾KU	
226.7	›=UøL•M u¡"É ¾T>ku`	1.›- 2. ¾KU	
226.8	ËÉM u¡"É ¾T>ku`	1.›- 2. ¾KU	
226.9	c=• u¡"É ¾T>ku`	1.›- 2. ¾KU	
226.10	TQì" SsÖ`	1.›- 2. ¾KU	
226.11	K?L /ÃÑKê/ ----------		
227	vKð¨< ÃÖkS<uƒ ¾'u[¨<" ¾SŸLŸÁ ²È Ÿ²=I ¾Ö?" É`Ïƒ 'u` ¾T>ÁÑ–<ƒ;	1.›- 2. ¾KU---------- --$	Q. 229
228	Ÿ²=I ŸMJ' Ÿ¾ƒ 'u` ¾T>ÁÑ–<ƒ;	1. ŸK?L ¾S"Óeƒ Ö?" É`Ïƒ 2. ŸÓM ¡K='>¡ 3. uQw[}cw ›kõ e`ßƒ 4. SÉG'>ƒ u?ƒ 5. K?L /ÃÑKê/	

229	KSŸLŸÁ ²È¨<" K›ÑMÓK~ ÃŸõLK<;	1. ›- 2. ¾KU	Q. 232
230	¾ŸðK< ŸJ' K›"É Ñ<w˜ƒ U" ÁQM ŸðK<;	1.K¨K=É Sq×Ö]Á w` --------X"+U-------- 2.K›ÑMÓKAƒ w`-----X"+U-----	
231	¾A`e- ÕÅ— ¾¨K=É SŸLŸÁ KS¨<cÉ u=ðMÑ< ¨Å²=I Ö?" É`Ïƒ • A"Ç=SÖ< ÃÑó÷†ªM;	1. • A²=I A"Ç=SÖ<• AÑóóLG< 2. K?L xª A"Ç=H@Æ• S¡^KG<-$ 88. ›L¨<pU 99. SMe ›M}cÖuƒU	Q. 233
232	¨Å K?L Ö?" É`Ïƒ • A"Ç=H@Æ ŸÑóñ KU";		
232.1	[ÏU Ñ>²? eKT>Áq¿	1.›- 2. ¾KU	
232.2	\p uSJ'<	1.›- 2. ¾KU	
232.3	Ø^ƒ ÁK¨< ›ÑMÓKAƒ • A²=I cKK?K	1.›- 2. ¾KU	
232.4	¾T>cÖ¨< ¾U¡` ›ÑMÓKAƒ ÅŸT" um eLMJ'	1.›- 2. ¾KU	
232.5	¾SŸLŸÁ ²È ›Ã'„‹ • A²=I Ømƒ uSJ"†¨<	1.›- 2. ¾KU	
232.6	SMe ›M}cÖuƒU	1.›- 2. ¾KU	
232.7	K?L /ÃÑKê/----------		
233	A²=I ¡K='>¡ ŸT>cÖ¨< ›ÑMÓKAƒ ¾ƒ—¨<" K°`e- }S^ß '¨< (¾}hK '¨<);		
233.1	u›ß` Ñ>²? ›ÑMÓKAƒ ScÖ~"	1.›- 2. ¾KU	
233.2	›ÑMÓKAƒ cß−‹ ÅI" eKT>c\	1.›- 2. ¾KU	
233.3	¾U¡` ›ÑMÓKA• †¨< Ø\" ¾}TEL eKJ'	1.›- 2. ¾KU	
233.4	¾T>ðKÑ¨< ›Ã'ƒ SŸLŸÁ SÑ–~	1.›- 2. ¾KU	
233.5	SMe ›M}cÖuƒU	1.›- 2. ¾KU	
233.6	K?L (ÃÑKê)----------		
234	uT>kØK¨< kÖa ÃSKdK< ;	1.›- 2. ¾KU	

¡õM 3:- u}KÁ¿ ¾¨K=É SŸLŸÁ ²È-‹ LÃ ¾°¨<kƒ ØÁo-‹ /K›Ç=e"
K}SLLi }ÖnT>-‹/

¡õM 3:- "/¡õM 1:- uTQì" ¨<eØ K}kSÖL†¨<

}.l	ØÁo" T×]Á	¾SMe ›T^ß" SKÁ	lØ` Ã²KM
235	uTIì" ¬eØ ¾}kSÖ¨< SŸLŸÁ ¨<eØ LÃ eKS•\ ¾T>Á[ÒÓÖ<ƒ A"È '¨<;	1.u}ÅÒÒT> ¾SŸLŸÁ¨<" ¡` uS'""ƒ 2. ›"É Ó²? ŸÑv U"U ¾T>ÁcÒ 'Ñ` ¾K¨<U 3. K?L/ÃÑKê----------	
236	¾¨K=É SŸLŸÁ ¾SËS]Á Ñ<w˜ƒ S† • A"Ç=SÖ< }kÖ\;	1.SSKe ¨ÃU kÖa ›ÁeðMÓU 2. Ÿ›"É ¨` v'c Ñ>²? ¨<eØ 3. Ÿ¨` u%EL 4. Ÿ›Sƒ u%EL 88. ›L¨<pU	
237	uTIì" ¬eØ YKT>kSØ ¾¨K=É SŸLŸÁ ØpU }'Óa-ªM;	1.›- 2..¾KU/›M}'Ñ[˜U 99. SMe ›M}cÖuƒU	
238	uTQì" ¨<eØ ¾¨K=É SŸLŸÁ Ÿ}kSÖM-u%EL U" ›Ã'ƒ kLM ‹Óa‹ K=•`-ƒ Ã‹LM;		
238.1	U"U ‹Ó` ›Ã•`U	1.›- 2. ¾KU	
238.2	ÁM}KSÅ" ÁMÖuk kLM ÅU ŸwMƒ Sõce	1.›- 2. ¾KU	
238.3	ŸwMƒ LÃ SÖ'—" ÁM}KSÅ ðdi SÚS`	1.›- 2. ¾KU	
238.4	w¡Kƒ (ISU)	1.›- 2. ¾KU	
238.5	›L¨<pU	1.›- 2. ¾KU	
238.6	K?L /ÃÑKê/---------- ----------		
239	ŸSÅu— kÖa– ¬ß ¨Å ¡K='>Ÿ< K=›S×– ¾T>‹M U" ›Ã'ƒ ‹Ó` c==•` '¬;		
239.1	U"U ‹Ó` ›Ã•`U	1.›- 2. ¾KU	
239.2	ŸvÉ ÁM}KSÅ ðdi ŸwMƒ Ÿ¨×	1.›- 2. ¾KU	
239.3	uTì" ¾T>kSÖ¨< SŸLŸÁ Ÿ¨× ¨ÃU c=Çce ¡\ ŸÖó	1.›- 2. ¾KU	
239.4	Ÿª‹—¬ JÉ ¡õM ISU c=cT	1.›- 2. ¾KU	
239.5	uÓw[eÒ Ó"–<'ƒ Ñ@²? IUU c=cT	1.›- 2. ¾KU	
239.6	¾c¬'ƒ S<kƒ SÚS`" w`É w`É c==M	1.›- 2. ¾KU	
239.7	›L¨<pU	99	
239.8	K?L /ÃÑKî/---------- ----------		
240	uTIì" ¨<eØ ¾T>kSÖ¬ ¾¨K=É SŸLŸÁ ²È KU" ÁIM Ñ>²? • `Ó´"" K=ŸLŸM	1.¯Sƒ---------- 88. ›L¨<pU 99. SMe ›M}cÖU	

	Ã‹LM;		
241	ÃI" ¾¨K=É SŸLŸÁ ²È SÖkU ÃkØLK<;	1.›- 2. ¾KU	

¡õM 3:- "/¡õM 1:- u¡"É LÃ ¾T>ku` ¾¨K=É SŸLŸÁ KT>¨eÆ

}.l	uØÁo" T×]Á	¾SMe ›T^ß" SKÁ	¢É lØ` Ã²KM
242	u¡"É LÃ ¾T>ku[¨< ¾¨K=É SŸLŸÁ ue"ƒ Ñ>²? Sk¾` ›Kuƒ;	1. u¾›Ueƒ ¯Sƒ 2. u¾ 2 ¯Sƒ 3. u¾3 ¯Sƒ 4. u¾3 ¨` 88. ›L¨<pU	
243	u¡"É LÃ eKT>ku[¨< ¾¨K=É SŸLŸÁ SÉ'>ƒ ØpU }'Óa-M;	1. ›- 2. ¾KU/›M}'Ñ[˜U 88. ›Leª¨<eU	
244	u¡"É LÃ eKT>ku[¨< ¾¨K=É SŸLŸÁ Ÿ}kSÖM- u%EL U" ›Ã'ƒ kLM ‹Óa‹ K=•`-ƒ Ã‹LM;		
244.1	U"U ‹Ó` ›Ã•`U	1.›- 2. ¾KU	
244.2	Ÿõ}— □A^e Uª T u=•`	1.›- 2. ¾KU	
244.3	w³ƒ ÁK¨< ÅU uwMƒ Sõce "K	1.›- 2. ¾KU	
244.4	¡wÅƒ uŸõ}— Å[Í SÚS` "K	1.›- 2. ¾KU	
244.5	›L¨<pU	88.	
244.6	K?L /ÃÑKê----------		
245	›ÑMÓKAƒ cß¨< ¾T>kØK¨< kÖa- S‹ A"ÅJ' 'Óa-ªM;	1. ›- 2. ¾KU/›M'Ñ[˜U	
246	u¡"É LÃ KT>ku[¨< ¾¨K=É Sq×Ö]Á ŸSÅu— kÖa- ¨<ß U" ›Ã'ƒ ‹Ó` u=Ÿcƒ '¨< ¨Å Ö?" É'Ïƒ K=SKc< ¾T>‹K<;		
246.1	U"U ‹Ó` ›Ã•`U	1.›- 2. ¾KU	
246.2	SŸLŸÁ¨< ¾Ñvuƒ ›Ÿvu= ¾SlcM& ¾SUÑM&TnÖM eT@ƒ c=•`	1.›- 2. ¾KU	
246.3	Ÿõ}— □A^e Uª T u=•`	1.›- 2. ¾KU	
246.4	w³ƒ ÁK¨< ÅU uwMƒ Sõce "K	1.›- 2. ¾KU	
246.5	¡wÅƒ uŸõ}— Å[Í SÚS` "K	1.›- 2. ¾KU	
246.6	›L¨<pU	88.	
246.7	K?L /ÃÑKê----------		

247	ÃI" ¾¨K=É SŸLŸÁ ²È SÖkU ÃkØLK<;	1.›- 2. ¾KU	

¡õM 4 :- ¾}KÁ¿ ›Ã'ƒ ¾Aˋ"ª• SS²—-‹

Ÿ²=I uª‹ uW"Ö[» ¾}kSÖ<ƒ 'Øx‹ }ÖnT>-‹ u›ÑMÓKA~ LÃ ÁL†¨<" ¾}KÁ¿ • AˋŸª¿‹" ÁdÁK<::

}ÖnT>-‹ ¾T>eTS<uƒ ŸJ' # u×U eTTKG<$ • A" #• eTTKG<$ ŸT>K¨< LÃ UM¡ƒ /✓/ ÁÉˋÑ<::

uSeTTƒ" vKSeTTƒ SŸŸM Ndw "K #}Gpx $ LÃ UM¡ƒ /✓/ ÁÉˋÑ<:: ¾TÃeTS<uƒ ŸJ' # u×U

›MeTTU$ #›MeTTU $ ¾T>K¨< LÃ UM¡ƒ/✓/ ÁÉˋÑ<::

}.l	¾›ÑMÓKAƒ ¯Ã'„‹	1 u×U ›MeTU	2 ›MeTU	3 }Gpx •	4 eTTKG<	5 u×U eTTKG<
248	¾›ÑMÓKAƒ cß¨< xqrarbe ›K¨<::					
249	Ÿ²=I Ö?" É'Ïƒ um" ¾}KÁ¿ ¾SŸLŸÁ ²È-‹ ÃÑ—K<::					
250	Ÿu?, ›eŸ Ö?" É'Ï~ ¾¨cÅw" c¯ƒ }eTS„"M					
251	¾U¡` ›ÑMÓKAƒ ¾}ÖkS¨< c›ƒ }eTT> '¨<					
252	ŸÅ[eŸ<uƒ ›ÑMÓKAƒ AeŸTÑ˜uƒ ÁK¨< ¾SqÁ Ñ>²? um '¨<::					

253	¾U¡` ›ÑMÓKAƒ ¾T>cØuƒ Kw‰" ›S‹ xª• ›K¨<::					
254	¾SqÁ xª¨< ¾}S‰† '¨<					
255	i"ƒ u?ƒ A"Ç=G<U ¨<H ÁK¨<" um '¨<::					
256	Ö?" É`Ï~ "èI" êÆ '¨<					
257	Ö?" É`Ï~ ›ÑMÓKAƒ ¾T>cØuƒ k"„‹ KSÖkU }eTT> "†¨<					
258	Ö?" É`Ï~ ›ÑMÓKAƒ ¾T>cØuƒ c¯„‹ KSÖkU }eTT> "†¨<					

ስለነበረን ግዜ በጣም አመሰግናለሁ!