

Assessment of quality of care in family planning services in Jimma Zone, Southwest Ethiopia

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Abstract

Background: Providing quality of care in family planning services is an important task for care providers so as to increase service utilization and coverage; however, little is known about the existing quality of care in such services.

Objective: To assess quality of care in family planning services in Jimma Zone, southwest Ethiopia.

Methods: A cross-sectional survey was conducted from January 20-24, 2003 in eight service delivery points in Jimma zone. Three modules consisting six elements of quality in accordance with Bruce-Jain framework were used; observation was made during 687 clients interacting with their providers (the number of providers was 17), exit interview was made with 635 clients, and facility audit was also carried out.

Results: More than 80% of unmarried clients were getting the service from non-governmental clinic. Sixty-nine (10.9%) and 14 (8.1% of those who reported problem) clients expressed dissatisfaction with waiting time and solutions given by the provider respectively. Method unavailability was the reason in most service delivery points for providing methods different from clients' choices. Most clients were not told method specific and other relevant information. Provider's special training and the time of the training have shown statistically significant difference on six and two quality of care indicators respectively. Majority of the service delivery points did not have copy of guideline and mechanism to make programmatic change based on clients' feedback; all were not supervised in the last three months prior to data collection.

Conclusion: Several constraints in the provision of the service are identified and recommendations are forwarded accordingly. [*Ethiop.J.Health Dev.* 2003;18(1):8-18]

Introduction

Global population did not reach one billion until 1800 but then grew rapidly, doubling by 1930 and reaching five billion in 1987. Today, the population totals 6 billion (1).

Future population trends will hinge on the fertility decisions of today's one billion men and women aged 15-24 years and on their ability and freedom to act on those decisions. "If they can exercise their right to choose, then we will be on the way to slower and more balanced population growth" (1).

Family planning services are unique in providing the means for couples to space or limit their births, as well as to stabilize the world's population (2). They also have a role in the reduction of maternal morbidity and mortality by their ability in reducing the absolute number of pregnancies among all women, reducing the number of pregnancies among high-risk women, and reducing the number of unwanted pregnancies that might otherwise end in abortion (3).

The Ethiopian population policy, which was adopted early 1993, has the objectives of reducing the total fertility rate; reducing morbidity and mortality, as well as raising the contraceptive prevalence rate to a national average of 44% by the year 2015 (4).

However, to be successful, family planning programs must be sensitive to the community being served and set in a manner that meets the user's needs (3); which can be addressed by improving their quality of care because the basis for action in family planning, as stated in the program of action of the International Conference on Population and Development, is to enable couples and individuals to decide freely and responsibly the number and spacing of their children, to have the information and means to do so, to insure informed choices and to make available a full range of safe and effective methods (5). Ready access to good quality care is key to the success of family planning and related reproductive health services. With ready access, people can easily obtain safe and effective services that meet their needs, free from unreasonable barriers. Good quality care includes courteous, supportive interactions that help clients express their needs and make informed choices and the technical knowledge and skills to provide family planning methods and other reproductive health care effectively and safely. Providers who offer ready access to good-quality care can see their success in terms of health, and satisfied clients who use family planning longer and more effectively (6).

Contraceptive prevalence would be 16 to 23 percent greater if all women lived in a cluster with the highest quality of care compared with the lowest, as revealed in the study

perceived competency and hostility of providers were responsible for many women switching service or stopping use of family planning services entirely, as shown in the study conducted in Kenya (8).

Despite extensive body of work, detailed information on the quality of services at the provider-client level remains surprisingly limited. In the absence of detailed information on the quality of services, policy discussions on this issue have remained general and concrete recommendations for improving services elusive (9).

Studies regarding status of quality of care in family planning services in our country are not carried out sufficiently; however, such studies in other developing countries showed the presence of low quality of care in such services being provided at service delivery points which contributed to lessened service utilization.

The objective of this study, therefore, is to assess the existing level of quality of care in family planning services in Jimma zone and formulate recommendations for improvement, which in effect increases service utilization and coverage.

Methods

This facility based cross-sectional survey was conducted in Jimma Zone from January 20-24,2003. Jimma Zone has a population of 2.4 million residing in an area of 18,413 sq. km making the population density about 130.7 persons/km² (10). There were two hospitals, 13 Health centers (HCs), 65 health stations and 20 health posts making the zonal health service coverage 41.7%; the contraceptive prevalence rate of the zone was 17%(11).

The subjects of these study were all female family planning clients who visited the service delivery points (SDPs) and all health workers who were providing family planning (FP) service during five data collection days; and six HCs (Agaro, Jimma, Shebe, Sokoru, Limu Genet, and Asendabo), Jimma Family Guidance Association (FGA) and Higher 2 Maternal and Child Health (MCH) clinics were the SDPs included that were providing the service to at least 10 clients per day based on their previous pattern of clients flow and this was the criterion used for selecting these eight SDPs so as to be cost effective. To control the variations among the working days and hours, all five working days of the week and all service hours of the days were included.

A total of 687 clients had visited the SDPs and observation was done while all of them were interacting with their

providers, but exit interviews were made with 635 clients (52(7.6%) were not willing to be interviewed). Seventeen providers were being observed while providing the service. Facility audit was carried out in eight SDPs.

Questionnaires with four different sections were prepared for client exit interview, observation during provider-client interaction, facility audit and method-specific checklist (additional for exit interview and observation). The instruments included six elements of quality in accordance with Bruce-Jain framework of quality of care, that include: method choice, provider-client information exchange, provider competence, client-provider interaction

(interpersonal relation), mechanism to encourage continuity, and appropriate constellation of services (12).

Six health officer and two medical interns conducted the observation during provider-client interaction, and females who completed twelfth grade and speaking both Amharic and Oromifa made client exit interview. Prior orientation on the application of the instruments was given. The observer was given a copy on importance of selected procedures for providing family planning methods that was adapted from "The essentials of contraceptive technology, a hand book for clinical staff" (6), which could make the observer able to evaluate whether the provider performed clinical procedure according to guideline considering the importance or not. The observer also collected data on facility audit. Clients were interviewed in a private area out of earshot of the SDP' personnel. A Personnel of the SDP under study was not involved in collecting data from that particular SDP. Data were checked for completeness and internal consistency at the end of each day of data collection.

Formal letter was written prior to the study and the results with the recommendations were disseminated to each SDP included in the study. Both the provider and the client were being asked for their willingness for the presence of the observer during their interaction. Confidentiality of the information gathered was assured to the interviewed clients.

The data were analyzed using SPSS 11.0. Appropriate tables and diagrams were used to present findings; Odds ratio (OR) and 95% Confidence Interval (CI) and Chisquare test were used to test statistical associations.

Results

I. Client exit interview

Among 635 interviewed clients, 130 (20.5%) were new clients and 505(79.5%) were continuing clients. Majority of clients, 353 (55.6%), were in the age group 25-35 years, the mean age of clients was 25.8 years (median 25 and the range was 14-48); 608 (95.7%) were married and 599 (94.3%) had one or more child and the mean number of children was 3 (range 1-9), 356 (59.4%) mothers were breast feeding at the time of data collection; 381 (60%) clients were Muslims, 366 (57.6%) were Oromo, 269 (42.4%) were illiterate and 555 (87.4%) were housewives; the mean monthly family income was 271.00 Birr (median 200.00 Birr and range 40.00-3,000.00), and the majority, 410(64.6%) clients have monthly income \leq 250.00 Birr (Table 1). Among 12 single clients, 10 (83.3%) were clients of FGA clinic and six health centers had

no such clients.

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The mean waiting time to get service was 31.7 minutes (median 15 minutes and range 1-240); 69 (10.9%) clients were dissatisfied with length of waiting time, 85 (13.4%) were neutral and the rest 481 (75.7%) were satisfied; the mean waiting time for which clients expressed dissatisfaction was 111.5 minutes (median 120 minutes and

range 5-240), neutral- 47.4 minutes (median 30 minutes and range 2-240) and satisfaction- 17.4 minutes (median 10 minutes and range 1-180) (Fig. 1). The mean waiting time

* 1 USD is 8.6 Birr

Table 1: **Socio-demographic characteristics of clients interviewed in eight SDPs, Jimma Zone, Jan. 2003**

<u>Variables (n=635)</u>	<u>Number</u>	<u>Percent</u>
Age		
15-19	62	9.8
20-24	191	30.1
25-35	353	55.6
36-49	29	4.5
Marital Status		
Married	608	95.7
Single	12	1.9
Divorced	13	2.0
Widowed	2	0.3
Ethnicity		
Oromo	366	57.6
Amhara	89	14.1
Gurage	58	9.1
Keffa	45	7.1
Dawro	36	5.7
Yem	33	5.2
Tigre	8	1.3
Religion		
Muslim	381	60.0
Orthodox	211	33.2
Protestant	34	5.4
Catholic	9	1.4
Educational level		
Illiterate	269	42.5
1-6 grade	190	29.9
7-12 grade	164	25.8
12+	12	1.9
Occupational status		
House wife	555	87.4
Government employee	31	4.9
Daily laborer	19	3.0
Merchant	18	2.8
Others	12	1.9
Monthly income*		
≤250	410	64.6
251-500	163	25.7
501-750	24	3.8
751-1000	30	4.7
>1000	8	1.2

suggested by those dissatisfied was 26.8 minutes (median 30 minutes and range 1-120). The longest waiting time (240 min) was recorded for 12 (17.9%) at Limu Genet Health Center; the mean waiting time for this particular SDP was 99.4 minutes which is longer than the mean of all SDPs; on the other hand, the mean waiting time at Asendabo health center was the shortest (6.7min) (Fig.2).

The mean consultation time was 3.1 minutes (median 2 minutes and range ½ -30); 26(4.1%) clients were dissatisfied with the length of consultation time, 97 (15.3%) were neutral and the rest 512 (80.6%) were satisfied. The mean consultation time for which clients expressed dissatisfactions was 1.3 minute (median 1 minute and range 1-4), neutral- 1.8 minute (median 1 minute and range 1-15) and satisfaction- 3.5 minutes (median 3 minutes and range ½ -30). The mean consultation time suggested by those dissatisfied clients was 7.8 minutes (median 7.5 and range 4 -15). The mean consultation time at Sokoru health center (4.7 minutes) was the longest, followed by FGA clinic (4.5 min) and the shortest was at Limu Genet Health Center (1.5minutes) where clients waited longer to get service. The mean consultation time for norplant (9.3 min) was the longest, followed by 3.1 minutes for oral contraceptive pills (OCPs) and 3 minutes for depot medroxy progesterone acetate (DMPA). For intra uterine device (IUD) and fertility awareness based methods, the consultation time was 10 minutes for each of them.

The majority of clients, 331(52.1%), were very satisfied with provider's behavior, 267(42.0%) were somewhat satisfied, 32(5.0%) were neutral but the rest 5(0.8%) were very dissatisfied; with maintenance of privacy, 353(55.6%) were very satisfied, 222(35%) were somewhat satisfied, 39(6.1%) were neutral, 18(2.8%) were somewhat dissatisfied and the rest 3(0.5%) were very dissatisfied.

The majority of clients, 417(65.5%) were not asked about their reproductive intentions before they started to use any of the methods; 355(55.9%) use DMPA, 275(43.3%) use OCPs, and the rest use other methods. Of 635 clients, 552(86.9%) were given chance to choose the method they want, whereas, this chance was not given to the rest 83(13.1%). The number of clients who got the method they chose, 501(78.9%) is lower than those who had been given the chance to choose; 134(21.1%) were obliged to use the method different from their choice, however, 11(8.1%) were not given explanation for not being provided with their choice. Among the reasons for not providing the client's choice, unavailability was told to 104 (84.6%), contraindication to 8 (6.5%) and necessity of paying 3.00 birr for DMPA to 11(8.9%) clients. The greatest proportion of clients who were not provided with their choice was in Jimma Health Center and the least was in FGA clinic (Table 2).

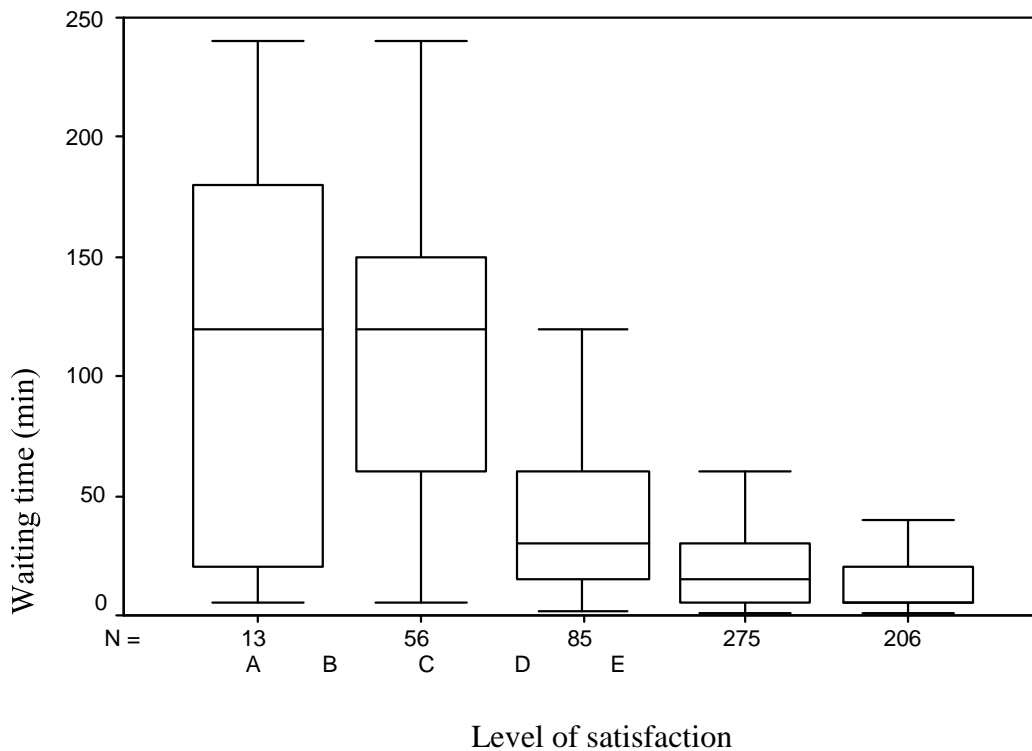


Figure 1: **Boxplot showing levels of satisfaction with waiting time in eight SDPs, Jimma Zone, Jan. 2003**
 (Boxes show the 5% distribution limits and bars the 97.5 distribution limits. Horizontal lines within the boxes show the median values (the extremes are not indicated))

Table 2: **Clients who didn't get the method they chose by SDP, Jimma Zone, Jan. 2003**
 Clients who didn't get their choice SDP

Total number of clients	Number	Percent
Jimma Health Center	79	57.0
Higher 2 MCM clinic	78	37.2
Asendabo Health Center	58	27.6
Shebe Health Center	76	23.7
Sokoru Health Center	51	15.7
Agaro Health Center	127	12.6
Limu Genet Health Center	67	1.5
<u>FGA clinic</u>	<u>99</u>	<u>1.1</u>
<u>Total</u>	<u>635</u>	<u>21.1</u>

Among 275 OCP users, OCP was not the choice for 113(41.1%) clients and among 355 DMPA users, DMPA was not the choice for 21(5.9%) clients. Dual method use was discussed for only 44 (6.9%) clients. Among 174 clients who reported problems, 14 (8.1%) were dissatisfied with the solution given by the provider, 11 (6.3%) were neutral and the rest 149 (85.6%) were satisfied. Majority of clients, 629(99.1%) were informed to come again. Only 155(24.4%) clients were given information about HIV/AIDS and other STDs and their preventions (Table 3).

A total of 17 providers (13 females and 4 males) were being observed in eight SDPs while providing FP service to 687 clients. Of 687 clients, 114 (16.6%) were new and the rest 573 (83.4%) were continuing clients; 663 (96.5%) were married and 16 (2.3%) were single. Among single clients, 13 (81.3%) were receiving service from FGA clinic and six health centers had no such clients. Six (35.3%) providers were clinical nurses, 4 (23.5%) were junior midwives, 2 (11.7%) were nurse midwives, 2 (11.7%) were health

assistants, and there were 1 junior clinical nurse, comprehensive nurse and midwife each comprising 5.9%. The mean service year of providers was 8.8 years (range ½ - 18). Only 9 (52.9%) providers had special training on FP service provision. All service delivery points, except

Asendabo Health Center and Higher 2 MCH Clinic, had at least one provider with special training. The time of special training ranged from 9 years back to less than one year with duration of 1-7 weeks.

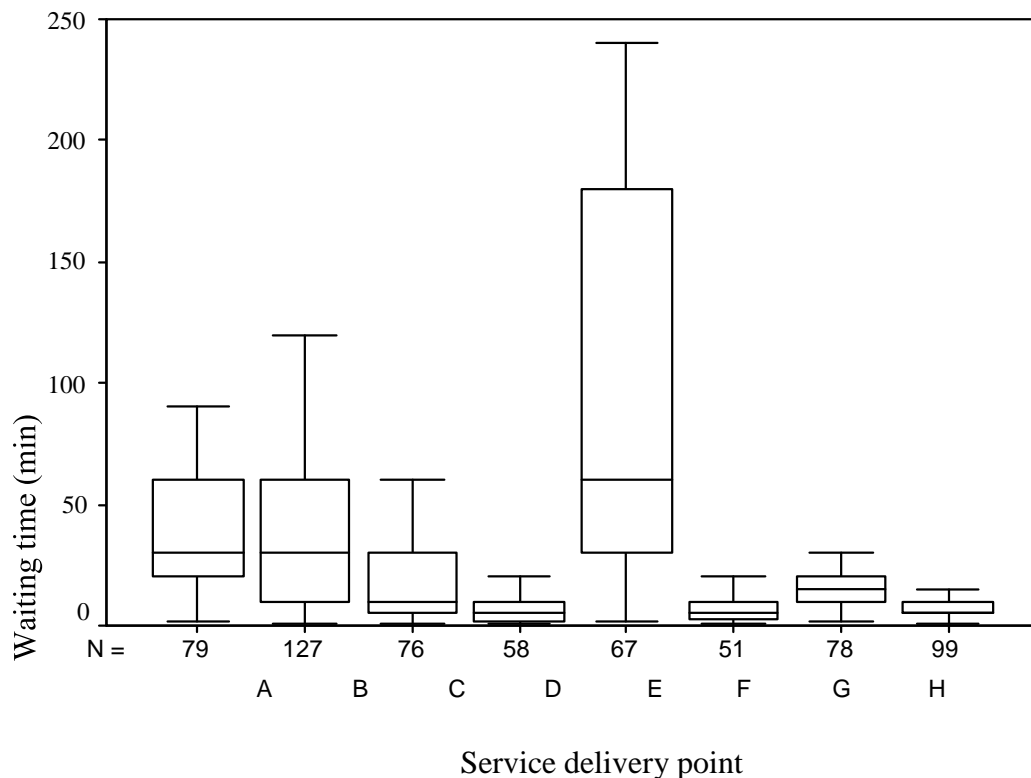


Figure 2: Boxplot showing waiting time by SDP, Jimma Zone, Jan. 2003.

Table 3: Clients who were informed about HIV/AIDS and other STDs and their prevention by SDPs, Jimma Zone, Jan. 2003

SDP	Information given		Total
	Yes	No	

No.		%	No.	%			
Sokoru Health Center	39	76.5	12	23.5	51		
Higher 2 MCH clinic	34	43.6	44	56.4	78	39.7	60.3
Asendabo Health Center	23		58				
Limu Genet Health Center	16	23.9	51	76.1	67		
16 Jimma Health Center		20.3	63	79.7	79	14.1	85.9
FGA clinic	14		99				
Shebe Health Center	10	13.2	66	86.8	76		
10 Agaro Health Center	3	2.4	124	97.6	127	24.4	480
<u>Total</u>	<u>155</u>		<u>75.6</u>	<u>635</u>			

Provider's special training showed significant association with assuring clients of confidentiality (OR=3.51, 95% CI=1.29-9.58), giving time and listening well to the client (OR=7.42, 95% CI=4.94-11.14), encouraging talking and asking (OR=5.46, 95% CI=3.94-7.58), assessing the awareness of HIV/AIDS and explaining their prevention (OR=7.83, 95% CI=1.79-34.34), performing clinical procedures according to guideline (OR=11.96, 95%

CI=5.67-25.22), following infection prevention procedures (OR=2.41, 95% CI=1.36-4.27), and considering or maintaining privacy (OR=13.18, 95% CI=8.59-20.21) (Table 4). The time of the special training also showed significant association with performing clinical procedures according to guideline (p<0.001), giving time and listening well to the client (p<0.001), and encouraging talking and asking (p<0.001) (Table 5).

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Total	363	61	14.4	424	100	470	68.4	217	31.6	687	100
		85.									
Odds Ratio	2.41					13.18					
95% CI	1.36-4.27					8.59-20.21					

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Table 5: Two quality of care indicators having statistically significant association with time of special training on FP service provision, in eight SDPs, Jimma Zone, Jan. 2003.
 Perform clinical procedure *Giving time and listening *Encourage to talk and

			acc. to guide line well to the client ask								
			Yes	No	Total	Yes	No	Total	Yes	No	Total
Time of training	With in this year	No	30	3	33	57	4	61	56	5	61
		%	90.9	9.1	100	93.4	6.6	100	91.8	8.2	100
	One year back	No	73	72	145	148	3	151	138	13	151
		%	50.3	49.7	100	98.0	2.0	100	91.4	8.6	100
	Five years back	No	0	18	18	18	0	18	1	17	18
		%	0	100	100	100	0	100	5.6	94.4	100
	Nine years back	No	23	98	121	95	29	124	66	58	124
		%	19.0	81.0	100	76.6	23.4	100	53.2	46.8	100
	Total	No	126	191	317	318	36	354	261	93	354
		%	39.7	60.3	100	89.8	10.2	100	73.7	26.3	100
	2		76.47		37.69		104.71				
χ Value											
	P Value		<0.001		<0.001		<0.001				

*Giving time and listening well, and encouraging talking and asking are considered as one quality of care indicator, i.e. demonstrating good counseling skills.

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Majority of continuing clients, 440(76.8%) were being provided with the same method they were using before. Among the reasons for not providing 133(23.2%) clients with the same method, unavailability of the method was told to 109(82.0%) clients and other medical reasons told to the rest 24 (18.0%) clients.

The providers were expected to make pregnancy checkup for all new clients before providing hormonal contraceptives. Among 114 new clients, the providers didn't check 25(21.9%) clients for pregnancy status.

Among 227 clients (continuing clients stating new method (133) and new clients (114)), only 71(31.3%) were being explained about various methods available. All 71 clients were informed about OCPs, 69(97.2%) about DMPA, 14 (19.7%) about IUDs, 10(14.1%) about barrier methods, 8(11.3%) about Norplant, 2 (2.8%) about surgical contraception, and 1(1.4%) about natural methods; more than 2 methods were explained for 24 (33.8%) clients and from whom 21(87.5%) were being allowed to make informed choice (9.3% of all clients starting new method). Six hundred forty two (93.4%) clients were encouraged to come again with proper specification of time.

Method specific checklist:

The number of clients using the methods other than OCPs and DMPA is very small (<4), so here we put the results for OCPs and DMPA only.

A. Client exit interview

OCPs

Among 275 OCPs users, 267(97.1%) were told how to take the first pill out of packet. How to follow arrows on the packet was told to 264 (96%), and 245(89.1%) were informed when to start new packet. The necessity of correct and consistent use was told to 251 (91.3%), and only 136(49.5%) clients were informed about what to do and how to continue if the pills are missed. Only 95 (34.5%) were informed about the reminder pills, and only 73(26.5%) clients were informed at least one common side effect of the method.

DMPA

Among 355 DMPA users, 328(92.4%) were informed about effectiveness of the method for three months, and 251(70.7%) clients were informed at least one common side effect of the method. Only 40 (11.3%) clients were informed to use condom or spermicide or to avoid sex if they become more than 2 weeks late for their next injection.

B. Observation

OCPs

Among 134 OCP users, 103 (76.9%) were informed how to

take the first pill out of packet, and 114 (85.1%) were told how to follow arrows on the packet to take the rest of pills each day. When to start a new packet was informed to 83 (61.9%) clients, and 65(48.5%) were told the necessity of correct and consistent use. Only 2(1.5%) clients were told about what to do and how to continue if the pills are missed.

Only 10(7.5%) clients were being explained about reminder pills, and only 6 (4.5%) clients were informed at least one common side effect of the method.

DMPA

Among 86 DMPA users, effectiveness of the method for 3 months was told to 62(72.1%) clients. Only 34(39.5%) clients were informed at least one common side effect of the method. To use condom or spermicide or avoid sex if the client becomes more than 2 weeks late for her next injection was informed to only 1 (1.2%) client.

III. Facility audit

Only 3 SDPs had a copy of MOH guideline of FP service in Ethiopia. Among the FP methods, progesterin only pills were available in all SDPs; there was also combined oral contraceptive pill except in Agaro Health Center. Only FGA clinic had all types of the methods. DMPA was not available in 3 SDPs in the majority of data collection days. Tubal ligation, vasectomy, norplant, spermicide, diaphragm and cervical cap were available only in FGA clinic. Condom was not available in Sokoru Health Center and Higher 2 MCH clinic. All SDPs had basic disposable items like needles, syringes and gloves, and had examination coach and clean water supply. Except Agaro Health Center, all SDPs had blood pressure measuring apparatus in their FP units. 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, except Higher 2 MCH clinic can offer privacy for pelvic examination or IUD insertion or during consultation time. The FP unit of Higher 2 MCH clinic was also being used as injection room for all kind of clients of the SDP. All SDPs didn't receive a supervisory visit on FP services in the past 3 months prior to data collection time. Only FGA clinic was found to have mechanisms to make programmatic change on the basis of client feed back; it has arranged extra office hours service for government employees, and also recruited full time general practitioner and laboratory technician to respond to clients' requests. Clients had commented regarding the payment for DMPA (3 birr) at Shebe Health Center but there was no change. Limu Genet Health Center was not providing FP service in the morning hours and for which significant proportion of clients were complaining but giving the service on those hours was neither started nor intended. All SDPs were being asked about any existing problem, and except FGA clinic and Sokoru Health Center, the rest SDPs responded as having problems. Lack of human power, unavailability of some methods, absence of health professional with special training, and frequent turn over of staff working in the unit were problems felt by the providers as having negative effect on the quality of their FP Service.

Discussion

Making comparison between care providers governmental SDPs and FGA clinic on their attitude towards unmarried clients was difficult because of the absence of such clients in

6 governmental SDPs during the data collection days. However, the presence of >80% of unmarried clients only in FGA clinic and their absence in six governmental SDPs could have some implication in terms of the general approach of the SDPs towards such clients, or the attitude of unmarried clients toward governmental SDPs could have hindered them from being served there. Studies in Kenya showed that unmarried clients were denied access to government clinics and provider attitudes keep them from receiving FP services; meanwhile, non governmental clinic providers were more likely to be sensitive to such clients than public clinics (13).

The major drawbacks in assessing clients' satisfaction are courtesy bias, low expectation of clients about quality of service in public SDPs and lower educational status of clients (being unable to question their treatment) (9,14), and this could have affected those significant proportion of clients who reported as being neutral and also some of those reported as being satisfied to questions for which their level of satisfaction was assessed. For instance, the proportion of clients who reported dissatisfaction with maintenance of privacy was only 21(3.3%), whereas, on observation, for 217(31.6%) clients, the provider didn't maintain privacy. This reflects the discrepancy of results between exit interview and observation, which can be further evidenced by: very low proportion of clients (5(0.9%)) who reported that they were not informed to come again, whereas, the observers noted that 45(6.6%) clients were not informed to come again.

In developing countries, waiting times, even with a prior appointment, are rarely less than 15 minutes. The study in rural Bangladesh showed that the average waiting time for MCH service (including FP) was 30 minutes and the proportion of clients who expressed dissatisfaction was 28.2% with an average 57.1 minutes, and the average suggested time was 10.6 minutes (15). The average waiting time in our study was 31.7 minutes which is a bit longer, whereas, the proportion of dissatisfied clients was lesser (69(10.9%)) with an average 111.5 minutes which is very much longer, and the average suggested time was 26.8 minutes which is nearly three fold, as compared to the above study. Some clients replied, as they preferred their stay in the SDP to be better than the stay in their home for that particular moment, when being asked about their being satisfied with longer waiting times. Though levels of satisfaction with waiting time is relative, it is found to be one potential area that affects clients' satisfaction with the service provided that needs consideration; as there was satisfaction with 180 minutes and dissatisfaction with 5 minutes, waiting time.

The above study (15) also showed that the average consultation time was 2.33 minutes and 8.3 % of clients were dissatisfied with an average 1.5 minute. The average time in our study was longer (3.1 min) and lesser proportion of

clients (26(4.1%)) expressed dissatisfaction with an average 1.3 minute.

The study in Ecuador showed that 63% of clients were asked about their reproductive intentions (14), whereas, our study revealed only 218(34.3%) clients as being asked. Asking reproductive intentions before initiation of contraceptive methods was very helpful for the appropriate choice of method and it could have helped avoid the dissatisfaction of some clients for whom their choice was not provided.

If there is no medical reason against it, clients should have the method they want. When clients get the methods they want, they use them longer and more effectively (6). However, our study revealed that 83(13.1%) clients were not given the chance to choose their FP method, and not all clients, who were given the chance, were provided with their choice. Of 635 clients, 134(21.1%) reported that they were given the method different from their choice. The proportion of continuing clients who were also obliged to change their previous method, because of method unavailability, was not few. Similarly, not few proportion of clients reported that they were using OCPs without being their choice. In addition, 11(8.1%) clients were not informed about the reason for not being provided with their choice. The proportion of clients who were allowed to make informed choice out of total clients starting new method was also very low. Except in FGA clinic where all methods were available, unavailability of the methods was the most frequently explained reason for not providing the clients' choice, and from the provider's point of view this might be considered as a factor for not explaining various methods and giving chance to choose; however, all service providers are expected to explain various methods and refer clients somewhere else for the method if not available (6).

Majority of clients (356(59.4%)) were breast-feeding at the time of data collection but none of them were encouraged to use lactational amenorrhea method. Natural method was explained for and used by one client only and that was fertility awareness based method. This might show that most service providers were not considering its importance and practicability. In here, dual method use could also play role in making natural method use more effective, however, it was discussed with 6.9% of clients only.

The proportion of clients who expressed dissatisfaction with provider's behavior was very small (5(0.8% of total clients)), whereas, 14(8.1% of clients who reported problems) were dissatisfied with solutions given by the provider. This could reflect low technical competence and/or low counseling skills in problem solving. Such

allowing informed choice could be the factors associated with service switching or stopping use of FP services entirely, as revealed in the study conducted in Kenya (16).

Regarding appropriate constellation of service, the study conducted in Uganda showed 30% of interviewed and 22 % of observed clients received information about HIV/AIDS and other STDs with their prevention (14). In our study, 155(24.4%) interviewed and only 18(2.6%) observed clients were provided with the information, which is lower compared to the findings in Uganda. The discrepancy in the proportion of interviewed and observed clients receiving the information might be due to clients who could report as having the information even if they obtained it from other sources. Regarding the information provided on the specific method, significant proportion of clients were not told some very important things, for instance, side effects of DMPA and OCPs. What to do and how to continue if pills are missed, were among the information conveyed to lesser proportion of clients in both exit interview and observation. There is discrepancy between the proportions of clients who received similar information in the two data collection techniques, which might be due to the clients' report based on the knowledge they acquired from previous visits or other sources. Such kind of discrepancy was also noted in the studies conducted in Uganda, Zimbabwe and Ecuador (14).

Several studies considered various quality of care indicators that could be assessed either by observation or exit interview or both (14). In our study, the reports of observers indicated that providers with and without special training on FP service provision have statistically significant difference on six quality of care indicators, showing providers with the training were found to be better on these indicators than providers without the training. Also, this might show the impact of special training on improving quality of care. The time of the training has also showed statistically significant difference, among providers with the training, on two quality of care indicators. This could show that the more recent the training is the more likely to be better on these indicators. The study in Tanzania indicated that training and improving problem solving skill of providers improved quality of care in FP services (17). By considering the importance of the special training in terms of providing FP services with improved quality of care, the guideline of FP services in Ethiopia also underscored the presence of minimum of 6 trained people in hospitals, 4 in health centers and 2 in health posts (4). However, in our study, 8(47.1%) providers were found not having special training.

For 25(21.9%) new clients, the providers didn't check whether they were pregnant or not; however, they were provided with hormonal contraceptives right away. In fact, the kit for pregnancy test was not available in 4(50%) SDPs, which was mentioned as a reason for not checking pregnancy, but according to the observers' report, the providers didn't consider checking pregnancy status because they didn't ask at least menstrual history. All SDPs had not received supervisory visit with in the last 3 months prior to data collection; however, it was one of the factors that improved quality of care in FP services in Tanzania (17).

To be successful, FP Programs must be sensitive to the community being served and set in a manner that meets the user's needs (3). However, except FGA clinic, all other SDPs had no mechanisms to make programmatic change on the basis of client feed back. The MOH guideline of FP services in Ethiopia, was to be used at all levels of SDPs (4); but, only 3 (37.5%) SDPs had the copy. It is clear that in the absence of the guideline, implementation of the stated objectives and principles for the betterment of quality would be difficult. In this guideline, it is recommended that there should be minimum reserve stock of various methods for three months. However, let alone the reserve stock, the most chosen method (DMPA) was not available and the range of method mix was minimal in a significant proportion of SDPs.

This study revealed several constraints in the provision of FP services with improved quality of care, which can be implied as areas of possible improvement, including: method unavailability, not allowing clients to make informed choices, lack of training, longer waiting time, inadequate information about specific methods, giving hormonal contraceptives without checking pregnancy status, less emphasis on supporting the use of natural methods, lack of appropriate constellation of services, absence of mechanism to make programmatic change based on clients' feed back, and absence of copy of guideline in most SDPs.

Therefore, provider's special training with regular refreshment schedules, special emphasis on strengthening providers' problem solving skills, and counseling efforts to all clients, making various methods mix available with reserve stocks, making kits for pregnancy test available in all SDPs, supporting the use of natural methods, setting mechanisms to make programmatic changes based on clients' feedback, emphasizing on appropriate constellation of services, making copy of guideline available in all SDPs, improving program management capacity at all levels, and considering the need for regular supervision are recommended. The reason for the absence of unmarried clients in most governmental SDPs, absence of supervisory visits and inadequate supply of contraceptives and other items require further studies.

Though the objective of this study was not to come up with suggestion of the use of more than one instrument in such studies, combination of data collecting techniques is found to be helpful in terms of evaluating full set of indicators and understanding both providers' and clients' perspectives that

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helps in encompassing all areas which may need improvements.

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