

# Quality of family planning services in northwest Ethiopia

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## Abstract

**Background:** The unmet need for family planning services in Ethiopia is believed to be high (36%) while the already available services do not appear to be optimally used by potential clients. It is thus expected that an assessment and improvement of the quality of family planning services could enhance family planning services utilization.

**Objectives:** The aim of this study is to assess the quality of family planning services provision in terms of clients' perspectives, technical competence and interpersonal relations of providers and resources for the provision of effective family planning services.

**Methods:** A cross sectional study that employed exit interviews with clients, service - provider interviews, observations of client- provider interactions and an assessment of the availability of the necessary resources was conducted in one hospital, two health centers, two health stations, and one non-governmental clinic operating in north west Ethiopia.

**Results:** Two hundred seventy clients and 14 service providers were interviewed while another 86 client- provider interactions observations also made. The majority of the clients (66.3%) responded that there was no adequate privacy in service provision sessions. About 18% said that it was difficult to understand the service provider or that she or he did not hold any discussions at all. Communication and privacy was worse in government institutions compared to the NGO clinic included in this study ( $P < 0.05$ ). About 98.5% of the clients were not asked about STD risk and only 3.0% of the respondents were advised to use condoms. The providers mentioned several unjustified restrictions (like menstruation, age, marital status, husband's consent) in which cases, they did not provide family planning methods. Deficiencies were also noted in the provision of information and communication with clients, infection prevention procedures, and adequacy and cleanliness of service giving facilities.

**Conclusions:** Several aspects of the quality of services observed by this study need to be improved and measures should also be taken to improve the provision of family planning services through training and maintaining adequate resources. [*Ethiop.J.Health Dev.* 2005;19(3):195-202]

## Introduction

Quality of care in family planning encompasses a wide range of issues including technical competence, choice of methods, information given to clients, interpersonal relationships and appropriate constellation of services (1). Several studies have shown that quality of care greatly influences the uptake and continuation of use of family planning services (1 -5).

In Ethiopia only two studies were identified on quality of care in family planning, both of which were conducted in Addis Ababa about a decade ago (6, 7). While one dealt with the clients' perspective in an NGO clinic, the other one included several health institutions. On the other hand, the Ethiopian population is growing at 2.9% per annum (8) and the unmet need for family planning is high, about 36% (9). The last Demographic and Health Survey reported that while the current use of family planning methods (contraceptive prevalence rate) among married women was estimated to be 8%, 17% have used a method of family planning at some time, indicating a high discontinuation (9).

Thus an assessment of the quality of family planning services will make possible the identification of problems that exist in the care of clients, enhance the attraction of

clients for family planning and ensure the continued use of the services.

The objectives of this study are to assess the perceptions, attitudes and experiences of family planning clients towards the services, investigate the technical competence, interpersonal relations, mechanisms to ensure follow up and examine the facilities and resources useful for the provision of effective family planning services.

## Methods

This study is a cross sectional study and has utilised several methods of data collection. The different methods either assessed the same aspects of the services in order to improve the validity of the conclusions or appraised different aspects of the services. The study was conducted in North Gondar administrative zone, northwest Ethiopia, which has a population of 2.8 million.

The study facilities included one hospital, two health centers, two health stations, and one non-governmental clinic that were randomly selected at each level. The number of health facilities selected at each level was based on the total number of health facilities available in

the zone and the number of clients served by the facilities.

All women of the reproductive age group - 15 - 49 years and who visited the selected health facilities over a three week period for family planning purposes were deemed eligible for inclusion in the study. The women included in the study sample were selected by the systematic random sampling method by setting a target, on the average, of five women per day. The sampling interval depended on the number of clients visiting the selected health facility on each day. Exit interviews were conducted by experienced and trained nurses drawn from other health institutions.

A total of 14 family planning service providers were interviewed including one from the hospital, five from the health centers, six from the health stations and two from the NGO clinic. The number of providers selected for the study was determined by the number of health workers providing family planning services in the health institutions. Such providers numbered about 20 in the selected health institutions. Out of the total of 15 family planning providers selected for the study, one provider from one of the health stations refused to participate. Clinic staff providing FP services at the selected study sites were observed by experienced and trained nurses from other health facilities. Client - provider observations were conducted using a checklist that included the approach of the health worker, communication between the provider and the client and the interventions made by the provider. Finally the availability and functionality of facilities for the provision of family planning and related services was assessed using a checklist.

Data were entered by experienced clerks and analyzed using EPI INFO version 6. Odds Ratio, 95 % Confidence Intervals and Chi square tests were used to assess the strength and significance of the observed associations.

Permission for conducting the study was secured from the Amhara National Regional State Health Bureau and the North Gondar Zonal Health Office. Consent was also obtained from all the study participants after they were briefed about the objectives and the procedures of the research. The questionnaires were anonymous and confidentiality was strictly maintained.

## Results

### *Exit Interviews*

A total of 270 clients were included in the exit interview. Out of these 211(78.1%) were continuing clients, 46 (17.0%) were new clients and 13(4.8%) were switching clients. The socio-demographic characteristics of the study population is shown in Table 1. The majority of the women belonged to the age group 20-29(46%), and were married (91.1%), Orthodox Christians (83.0%), unable to read and write (50%), combined household activities

with farming (57%), and had 1-3 births (54.8%).

The most commonly used family planning method was the injectable 201(74.4%) followed by the combined pill 54(20.0%) and progestin only pill 9(3.3%). Three clients got IUCD (1.1%) while one client (0.4%) received Norplant. Two clients said they did not get any contraceptive.

**Table 1: Socio-demographic characteristics of family planning users in North Gondar, Ethiopia, Oct-Dec 2002**

Characteristics	Number (%)
<b>Age</b>	
15 – 19	44(16.3)
20 – 29	123(45.6)
30 – 39	76(28.1)
40 – 49	27(10.0)
<b>Marital status</b>	
Single	16(5.9)
Married	246(91.1)
Divorced	7(2.6)
Widowed	1(0.4)
<b>Religion</b>	
Orthodox Christians	224(83.0)
Muslims	42(15.6)
Others	4(1.5)
<b>Educational status</b>	
Illiterate	134(49.6)
Elementary (1 – 6 grades)	35(13.0)
Secondary ( 7-12)	95(35.2)
Above 12 grade	6(2.2)
<b>Occupational status</b>	
Housewife and farmer	154(57.0)
Housewife	59(21.9)
Government employee	16(5.9)
Student	14(5.2)
Merchant	8(3.0)
Local drink seller	5(1.9)
Daily laborer or maid	3(1.1)
Unemployed	5(1.9)
Other	6(2.2)
<b>Number of births</b>	
0	20(7.4)
1 - 3	140(51.9)
4 - 12	110(40.7)
<b>Number of alive children</b>	
0	24(8.9)
1 - 3	148(54.8)
4 - 12	98(36.3)

Twenty one (7.8%) of the women did not get the desired method while two women said they did not get any method at all. Sixteen of the 21 women answered that they did not get the method they wanted because they were not undergoing menstruation. Four women said that they missed appointments and, in one case, the method was out of stock. The reason given by the two women who did not get any method at all was not having menstruation.

Two hundred (74.1%) of the FP clients said that they chose the methods with the assistance of the provider while in 22.4% of the cases the provider by himself/herself selected the method. Seven clients (12.0%) from the health stations expressed disappointment because the services were rendered only during the afternoons.

For the new and switching clients, the most commonly discussed contraceptive was the injectable - 45 (78%) followed by the combined pills 35(60%). The issue of condom was discussed with 7(12.1%) clients. Progestin only pill and Norplant were discussed with 6 (10.3%) clients each. No discussions, however, were made on

female sterilization. Twenty one (36%) of the new and switching clients were asked by the service provider if the husband consented whereas the rest 37 (64%) answered that they were not asked.

For 222 (82%) of the women the provider was easy to understand. Twenty seven (10%) said the provider was difficult to understand and 4(2%) said they did not understand most of the things that the provider discussed. Seventeen (6%) of the women answered that there was no discussion or explanation by the provider. More difficulties in understanding including holding no discussion at all with the provider were observed in government health institutions compared to the NGO (FGAE) clinic (Table 2). Only 34% of the respondents answered that there was enough privacy during the consultation.

**Table 2: Ease of understanding of health workers and privacy during consultation in government health stations, health centers, hospitals, and FGAE clinic, North Gondar, Ethiopia , Oct-Dec 2002**

Health institutions	Clarity of understanding		
	Difficult or no discussion	Easy to understand	OR(95%CI)
Government health centers and hospitals	38	117	10.7(2.4, 66.4)**
Government health stations	8	39	6.8(1.2,48.8)**
NGO ( FGAE) clinic	2	66	1.0*
Health institutions	Privacy		
	Not adequate privacy	Adequate privacy	OR(95%CI)
Government health centers and hospitals	141	14	674(88.5, 1409**)
Government health stations	37	10	247(30, 5419) **
NGO ( FGAE) clinic	1	67	1.0*

\* - referent category

\*\* - significant associations (P<0.05)

It was also found that 266 (98.5%) clients were not asked about the STD risk during the service provision session while only 3.0% of the respondents were advised to use condoms. Emergency contraception was discussed only with 5(1.9%) of the clients.

**Provider Interview**

Three of the providers were senior nurses or midwives, one was a junior nurse, nine were health assistants, and one was a front line health worker. All the providers had basic training on family planning. Six of the fourteen respondents said that the basic training was adequate in all components of MCH services including family planning. The rest said that the basic training was inadequate or they were unable to make a judgment on the adequacy of training. Nine respondents said they had in service training. The mean number of years elapsed after the last in service training was 4.9± 3.0 and it ranged from one to 10 years.

Table 3 shows the types of family planning methods provided by the health institutions and the conditions that restrict the provision of family planning methods. The data obtained from one of the interviewees was incomplete, but all health institutions were represented.

The minimum age restriction for the combined pills was mentioned to be 15 years by four respondents while the maximum age ranged from 38 – 50 years as mentioned by seven respondents. Six respondents answered that they would not give combined pills for breast feeding mothers while the rest said that it is not restricted. Age restrictions for the Progestin-Only-Pill were the same as those for the Combined Pill. Restrictions concerning IUCD included being unmarried (as reported by two health workers) at least one child (as reported by another two health workers) husband’s consent and minimum age of 18 years as noted by one respondent each. Restrictions for injectables included a maximum age of 40 years according to one respondent and 45 years according to three respondents. The three respondents who acknowledged that female sterilization is conducted in their health institutions said they didn’t know if there were restrictions by age and breastfeeding status. One of them noted that it is restricted to conduct sterilization without the consent of the husband.

In the case of a woman who is not having menstruation and who seeks to use pills, 6 respondents said that they would tell her to come back when she has menstruation, 4 said they would tell her to use barrier methods and that

she should comeback when she has menstruation. One health worker said a pregnancy test would be performed. Seven respondents answered that a woman who is taking Depo- Provera could get the injection if she is late by only two weeks. One said that she could be late for 4 weeks, 3 gave other answers and one did not know.

Shortage of contraceptives, particularly injectables, was mentioned to exist in all health institutions

#### **Client-provider interactions and an assessment of the working environment**

Client-provider observations were made for 86 clients. The study population included 55 continuing, 29 new and

2 switching family planning clients. An average of 14.3 observations (range 8 – 20) was made per health facility.

In 64 (74%) of the cases the provider greeted the clients during the beginning of the session. Twenty one (36.2% of the new and switching) clients were asked by the service provider if the husband consented.

In none of the consultations did the provider use flip charts, brochures/pamphlets, or other IEC materials except for samples of contraceptives that were used in 19(22%) of the consultations. The average consultation time lasted for  $10.1 \pm 4.1$  minutes with a range of 4 – 25 minutes.

**Table 3: Conditions restricting the provision of family planning methods to clients, North Gondar, Ethiopia , Oct-Dec 2002**

Family planning method	Institutions providing the service	Minimum age	Maximum age	No of children	Breast feeding	Unmarried	Husband's consent
Combined pill	6	4 resp-15 years	1 resp-38 ears 4 resp-45 years 1 resp-49 years 1 resp-50 years	All resp-NR	6 resp-Yes	All resp-NR	All resp-NR
Progestin only pill	6	4 resp-15 years	1 resp-38 years 4 resp-45 years 1 resp-49 years 1 resp-50 years	All resp-NR	All resp-NR	All resp-NR	All resp-NR
IUCD	3	1resp-18 years	All resp-NR	2 resp-1	All resp-NR	2 resp - Yes	1 res – Yes
Injectables	6	1 resp-13 3 resp-15	1 resp-40 years 4 resp-45 years	All resp-NR	All resp-NR	All resp-NR	All resp-NR
Norplant	1	All resp-NR	All resp-NR	All resp-NR	All resp-NR	All resp-NR	All resp-NR
Condom	6	1 resp-12	All resp-NR	All resp-NR	All resp-NR	All resp-NR	All resp-NR
Female sterilization	2	All resp-DK	All resp-DK	2 resp - NR 1 resp - DK	All resp-DK	All resp-NR	1 resp- Yes 2 res - NR
Emergency contraception	4	All resp-DK	1 resp-45 years 1 resp-50 years 4 resp-DK	All resp-DK	All resp-NR	All resp-NR	All resp-NR

resp – respondents

DK- Don't know

NR-No restrictions

Table 4 shows the application of infection prevention procedures and the reasons for not conducting such procedures. Gloves were not used in 82 (95.3%) of the 86 cases. In 78(95.1%) cases they were said to be not applicable whereas in four cases (5%) they were not available. Proper disposal of sharp objects was not made in 54(62.8%) cases while in 36 (66.7%) cases, proper disposal containers were not available and the health workers did not apply the procedures in four other cases even if waste containers were available. Washing hands

with soap and water before and after performing the procedures was not conducted when needed in 33(41.2%) and 27 (33.8%) of the cases respectively.

No client was given a condom during the consultations and only one client was told about places where he/she could get condoms. Eighty clients were able to access a family planning method and one was prescribed to get a family planning method. In addition, three clients got other drugs.

**Table 4: Infection prevention procedures and the reasons for not conducting the procedures, North Gondar, Ethiopia, Oct-Dec 2002**

Infection prevention procedures	Conducted	Not conducted	Reasons for not conducting the procedures		
			Not applicable	Not available	Procedure neglected
Use gloves as appropriate	4	82	78	4	0
Use sharp disposal objects	32	54	14	36	4
Wash hands with soap and water before procedure	6	80	13	34	33
Wash hands with soap and water after procedure	9	77	14	36	27
Hazardous waste disposed in leak proof containers	0	86	86	0	0

Table 5 illustrates information that is provided to clients about the family planning methods and drugs/medications provided to the clients. Seventy three (84.8%) clients were told when to take the family planning methods but the possible side effects of the methods were discussed only for 25 (29.1%) clients.

Seventy (81.4%) clients were told when to return for a follow up visit, 8 were not told to do so and 2 were told that they did not need a follow up. No discussion was made about bringing about behavioral changes with any

of the clients. Twenty four (27.9%) clients were told what to do if they experienced any problems before the next visit while the remaining 62 were not. No referrals were made during the whole period of observation. Six clients were asked by the provider if they had any questions while the remaining 80 clients were not. The observers indicated that there was no privacy in 20 (23.3%) cases, inadequate or no explanation in 10 (11.7%) cases and dissatisfaction in three cases because the clients did not get the methods.

**Table 5: Information given to clients about the family planning methods and drugs/medications provided, North Gondar, Ethiopia , Oct-Dec 2002**

Information on family planning method	Informed	Not informed
Dose of family planning method/drug	36	50
When to take the family planning method/ drug	73	13
Possible side effects of family planning methods/drug	25	61

No brochures or hand outs were made available for clients on STIs in the study health institutions. Brochures or hand outs were available on family planning, MCH, and HIV/AIDS in only one health institution.

Waiting rooms were found to be unclean in one health institution and it was not also providing protection from rains in another health institution. The examination room was found to be unclean, narrow and lacking in privacy in three health institutions. Staff uniforms were not neat in three of the health institutions. The storage room was commented to be unclean and/or unordered in three health institutions.

Adequacy in auditory and visual privacy during examination was witnessed in only one health institution. Water was adequate in three health institutions but equipment such as blood pressure apparatus were found to be inadequate (only one apparatus per facility). Sterilizing equipment, gloves, weighing scales, examination beds were also inadequate in all government health institutions and, in some cases, were nonexistent. Sharp objects and needles were incinerated or buried only in two health institutions at the end of each day.

### Discussion

The socio-demographic characteristics of the respondents were found to be similar to the population of the zone in certain aspects like religion and marital status. However, because this is an institution-based study, it represents the characteristics of health service beneficiaries who in some aspects may differ from the general population of the zone. This is reflected by the literacy status of the population and the average number of births. The study population may have some differences from the general population in terms of education, income, knowledge about the services, and the capacity to care for one self. It is encouraging to note that a majority of the clients in

this study accessed the family planning methods they wanted. However, not having menstruation at the time of appearance at the health institutions was the most important reason for not getting the desired family planning method (16 out of 21) or not getting any method at all (2 out of, 2 cases). Studies elsewhere have also shown that the majority of non – menstruating women who come seeking contraceptives are denied the services (10). On the other hand, this may indicate that only a small number of women appear at the health institutions when not under menstruation and women may not seek family planning services if they knew that they would not be given the services.

The most commonly used family planning method was found to be the injectable (74.4%) followed by the combined pill (20%). The type of family planning method received is influenced, among other things, by knowledge about family planning methods and the availability and acceptability of the method by those who use the services. In this study, the injectable appears to be the most preferred family planning method perhaps because of its long term effect. In the injectable, there is no need to worry about remembering to use it daily or when somebody has sexual intercourse. The method also avoids frequent visits to health institutions for supplies. Studies have shown that use of injectables has been progressively growing in sub-Saharan Africa (11,12, 13). Of particular interest in these studies were the higher levels of use of injectables among rural women, women whose partners disapprove of family planning, uneducated women and women less frequently exposed to family planning education through the media. The preference by these groups of women for injectable contraceptives indicates the need to make it available and accessible to Ethiopian women, the majority of whom share the mentioned disadvantages. The introduction of injectables has highly improved family planning

coverage in Zimbabwe (13). In addition, the injectables and the pills were the most commonly discussed methods to new clients by the providers which may give clients restricted choices. The condom, which is the most important method of “Dual Protection” against unwanted pregnancy and STIs/HIV/AIDS, appears to get less attention. No discussion was made concerning permanent methods of contraception including in health institutions where these procedures are undertaken. It seems that efficient and effective methods for limiting the number of children (stopping child bearing) are neglected and those who need them may not be aware of the possibility of having such chances.

About 74% of the family planning users in this study chose the methods themselves which apparently shows the appropriateness of providing the services and that it should be extended to all users. Such practice is expected to increase satisfaction and sustained use. A point of consideration at this juncture though is that allowing clients to choose a method is useful only when the client has adequate and quality information on all the relevant methods.

In general this study shows that a high proportion of the respondents (82%) have found the health service providers easy to understand. It is, however, worth noting that, in the government institutions, a relatively high proportion of the respondents answered that it was either difficult to understand the health provider or no discussion at all was made. The problem was more frequent with the increase in the level of the health care system. About one fourth of the respondents at health centers and hospitals studied said they did not understand the service provider.

A majority of the respondents in this study (66.3%) also responded that there was no adequate privacy. Privacy was particularly poor in government health institutions. This was also confirmed during the client provider interactions observation where, in a number of instances, there was no adequate visual and auditory privacy. Privacy is one of the main criteria required for assessing quality of care (1). The lack of privacy could be one of the major obstacles for initiating and continuing care.

A great majority of the clients (99%) were not asked about STI-related risks while only 3% were advised to use condoms. Thus in Ethiopia, which is one of the hardest hit countries by HIV/AIDS in the world and the third in the number of HIV infected people in sub-Saharan Africa (14) such an opportunity is, thus, missed for HIV/AIDS prevention and control.

Emergency contraception was discussed with only five clients. Thus potential clients would not be able to know about it and use it.

About 36% of the clients were asked if their husbands consented to the use of FP methods, although it was not further assessed that any decision about delivering the method was based on such a factor. Asking a husband's consent might discourage the use of family planning methods and perhaps even violate the rights of clients. Besides, the Manual on Maternal and Child Health Care produced by the Federal Ministry of Health asserts that “*Wives need no permission of the husband to use family planning*”(15).

Some clients have complained that the services are not being conducted in the mornings. In static sites (health institutions, not outreach sites) Maternal and Child Health and Family Planning services are expected to be undertaken daily, meaning perhaps at all working hours in an integrated manner (16). Such an approach is expected to increase sustained utilization and satisfaction with the services.

All the service providers who participated in this study had basic training on family planning. However, less than half of the respondents answered that the basic training provided in family planning and MCH was adequate. Further assessments on the reasons for the claim were not done in this study. It is thus important to further explore this issue for possible improvement in the basic training of health workers.

Out of the 14 respondents nine in the study answered that they had had in-service training in family planning while the rest 5 answered they did not attend training. The number of health workers who underwent in-service training on family planning service provision was greater than the other components of MCH. On the other hand, the mean number of years passed since a health worker had had in-service training was about five. In the face of possible inadequacy in basic training, the in-service training was not thus satisfactory as a number of respondents did not have training after leaving training institutions and those trained have had it a long time ago. Since the in-service training was generally conducted years ago for many of the providers there is little chance for the health workers to get up to date on current concepts and practices.

In this study it was found that several restrictions are imposed on women who use different types of contraception. Such restrictions result in impediments to or denial of contraceptive use that can not be scientifically justified (17, 18). The restrictions observed in this study include young age, being married, the number of children one has and the consent of the husband. Many of these restrictions do not appear to have any legitimate or health related reasons. Age restrictions for non smoking women are no more important contraindications for oral contraception (19). The restrictions concerning IUCDs mentioned by some of the

health workers include being unmarried and having at least one child. This will exclude a lot of women with no sound justifications. Ten respondents answered that they would not provide pills to women who do not have menstruation at the time of their visit and would tell them to return when menstruation starts. As mentioned earlier not having menstruation was the most important reason for not getting the desired contraceptive method. This is discouraging as women may not return to the health facilities. Studies have identified menstruation requirements to be significant barriers to contraceptive use in developing countries (20). A comprehensive assessment would lead to a reasonable conclusion of whether a woman is pregnant or not. Thus using the absence of menstruation as a way of ruling out pregnancy is a major hindrance to contraceptive use.

Concerning Depo Provera, which is the most commonly used contraceptive, four respondents answered that a continuing user of this contraceptive should not get it if she is late by two weeks. In general it appears that there is no uniform action and knowledge about what to do if a client taking Depo-Provera comes later than the appointed time.

The respondents in this study gave different answers concerning the follow up of women who had IUCD inserted ranging from one month to three years. The Ministry of Health recommends a follow up after three months if no problems arise (16).

Client-provider interactions observation revealed that no teaching aid materials (except samples of contraceptives) were used while informing, communicating or counseling with clients. The effect of IEC in the provision of family planning services was not assessed in this study. However, ineffective IEC and counseling may result in frustration, discontinuation and method failure with all its consequences.

A number of infection prevention procedures were not applied when indicated. The reasons were associated with the unavailability of the necessary materials and not giving the necessary attention by the health provider. Not following the infection prevention procedures can have disastrous consequences for the clients as well as for the provider and should be considered as a matter of priority. This is particularly important considering the high prevalence of HIV/AIDS in the country.

No client was given condoms during the observations which are similar to the results of the client interview where only 7 clients received condoms. This once again indicates that condom as a family planning method or a method of "Dual Protection" is rarely provided in health institutions.

The discussion about the family planning method

supplied to the clients also seems unsatisfactory. For example the possible side effects of the methods were discussed only with 25 clients. This was the case when fear of side effects was mentioned as one of the reasons for not using contraceptives. The lack of discussion would not allow clients to understand the actual side effects (not rumors) and know the measures that could be taken to avoid or minimize these side effects and seek solutions in case of problems. Lack of such information may enhance method discontinuation and spreading of false rumors about side effects.

The inadequacy of equipment and supplies including highly demanded contraceptives and cleanliness of rooms should be a cause for concern. In addition to the discomfort to clients and patients served by the health institutions, these deficiencies may also be causes of health problems. It is particularly important to note that sharp objects and needles may not be disposed regularly and properly, creating potentially great hazard for the community and health service providers. Thus the prevailing conditions in some of the institutions may erode the trust of the people towards the services.

Interviews with clients by health workers, though not from the same institution, may potentially introduce social desirability bias. The interviewers were trained to explain the purpose of the study that no one will be disadvantaged in any way for giving a particular answer, and that only telling the truth as they perceive it can help to make suggestions for the improvement of the services. This has perhaps helped to decrease the desirability bias, but such bias might still have persisted in favor of presenting the services as good and not telling some problems of health services. In addition, the use of other methods such as client-provider interactions and facility functioning assessment might fill some of the gaps that might have arisen from such biases.

In conclusion, it is necessary to underscore that multi dimensional measures are needed to improve the quality of family planning services in Ethiopia. Service providers should also give due attention to all the relevant family planning methods; particular emphasis needs to be given to STI risk assessment and condom use ("Dual protection"), long term and permanent methods and emergency contraception. There is a need for improving the supply of contraceptives and other resources and their effective management, and for regularly training health workers. Training should involve both the technical aspects (family planning methods provision, unnecessary restrictions) and communication and counseling skills of service providers. The clinic environment should also be improved through maintenance of privacy and hygiene. The sharing of experiences between the public and NGO institutions may also help to improve quality of care in family planning as the latter appear to be at a better position in certain aspects of the services.

**Acknowledgments**

This study was funded by Family Health International (FHI) through the Ethiopian Public Health Association (EPHA) for which I am grateful. My heart-felt thanks also go to Dr Maggwa Ndugga, (Director FHI, East Africa), Dr Karen B. Allen (former FHI advisor) for their immense contributions in the design of the study and facilitating the research. Mr Ali Beyene (EPHA), Ms Kristen Kruger (FHI) and Mr Yenchun Tawye (FHI) are also thanked for assisting in the smooth progress of the research.

I would also like to express my gratitude to all personnel from the zonal health office head up to the smallest health unit in Gondar, who showed high enthusiasm and collaboration in the study. Last, but not least, I am also grateful to the participants of the study.

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