

**ORIGINAL ARTICLE****QUALITY OF FAMILY PLANNING SERVICES IN PRIMARY HEALTH CENTERS OF JIMMA ZONE, SOUTHWEST ETHIOPIA****Fikru Tafese<sup>1</sup>, Mirkuzie Woldie<sup>1</sup>, Berhane Megerssa<sup>1</sup>****ABSTRACT**

**BACKGROUND:** Good quality of care in family planning (FP) services help individuals and couples to meet their reproductive health needs safely and effectively. Therefore, assessment and improvement of the quality of family planning services could enhance family planning services utilization. This study was thus conducted to assess the quality of family planning services in primary health centers of Jimma Zone, Southwest Ethiopia.

**METHODS:** A cross-sectional facility based study was conducted from March 1<sup>st</sup>-25<sup>th</sup>, 2011 among family planning clients of government primary health care centers in southwest Ethiopia. Exit interview of 301 family planning clients identified through systematic random sampling technique was carried out using a pre-tested structured questionnaire. Availability of resources was checked using provider interview and inventory checklist. Moreover, a total of 150 consultation sessions were observed using checklist. Descriptive statistics and linear regression coefficients were generated to meet the objective of the study.

**RESULTS:** There was a shortage of some medical equipment, trained staffs, and information education and communication materials (IEC) in all of the family planning clinics. The mean waiting time at the service delivery points and consultation duration were 16.4 and 10.5 minutes, respectively. The providers used at least one information education and communication material in 33.3% of the consultation sessions. The overall satisfaction score was 8.64. Clients' perception on adequacy of information during consultation ( $\beta=0.24$ ; (95%CI=0.02-0.16) ease of getting the clinic site, short waiting time ( $\beta=0.17$ ; 95%CI=0.15-0.29) and educational level ( $\beta=0.09$ ; 95%CI =0.09-0.29) were significantly associated with overall satisfaction.

**CONCLUSIONS:** The findings of this study showed that there was lack of critical resources for the provision of quality family planning services in all of the primary health care centers included in the study. This has affected important aspects of service provision including the use of IEC materials during consultations. Hence, it is advisable that health managers of the health facilities and the district health office ensure improved availability of trained personnel, IEC materials and other supplies at the clinics.

**KEYWORDS:** Family planning, quality of FP services, client satisfaction, Jimma Zone

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**INTRODUCTION**

Quality is an essential element of any service if it is to attract and retain clients. Historically, quality has been defined at a clinical level, and involves offering technically competent, effective and safe care that contributes to the client's well-being (1,

2, 3, 4). According to the United States Institute of Medicine, "Quality of health care is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge" (3).

Quality of family care includes, but is not limited to, availability of the services and/or

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supplies, characteristics of health care provider, adherence to the standard of care and client's expectation and perception. For clients, quality is related to availability, waiting time, privacy, information and services received. On the other hand, for health service provider's quality is linked to outcome of services, safety, decline in morbidity and mortality and increase in services coverage (3, 4, 5, 6).

There is a broad agreement among the international and national communities that it is important to continue to improve the quality of healthcare (4, 5, 6, 7). All over the world, attempts to improve the health of mothers and children have been ongoing since the beginning of the nineteenth century. The *International Conference on Population and Development* (ICPD) in 1994 redefined reproductive health (RH) services to include FP. Family planning programs in many developing countries, including Ethiopia, focus efforts on achieving certain demographic goals such as birth-rate reductions and slower population growth through increased use and coverage of family planning services (5) which is clearly affected by the quality of family planning service available to the population. Family planning is also considered as one of the strategies for the reduction of maternal and child mortality rates which largely depend on the quality of the services provided to the population (8, 9, 10).

Hence, good quality family planning service helps individuals and couples to meet their reproductive health need safely and effectively (12, 13, 14). 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 (9, 10, 11). Moreover, clients have the right to be treated with privacy and dignity, receive information and the chosen contraceptive methods safely (15, 16). Availability of resources including materials and skilled personnel affect the process of FP service delivery which consequently predicts the service quality (17, 18, 19, 20). In this study, Donabedian quality of care framework (structure, process and outcome) was used to assess the quality of the FP service and we used client satisfaction as the outcome variable (21). Client satisfaction is considered as one of the desired outcomes of health care and it is

directly related to utilization of health services. Hence, measuring client or patient satisfaction has become an integral part of hospital/clinic management strategies across the globe (22, 23, 24).

Despite the abundance of research works in quality of care in general, there are few works focusing of the quality of family planning services in Ethiopia and the present study area. Hence, the objective of this study was to assess the quality of family planning services in primary health centers of Jimma Zone, Southwest Ethiopia. This assessment is believed to make it possible to identify problems that exist in the care to clients and to switch on the solutions, enhance the attraction of clients for family planning and also ensure continued use of the service.

## SUBJECTS, MATERIALS AND METHODS

The study was conducted in Jimma Zone governmental primary health centers. Jimma Zone is one of the 18 zones in Oromia Region. Jimma Zone has 18 Woredas and its main city, Jimma Town, is located 357 kms away from Addis Ababa in the southwest. A cross-sectional health facility based study using quantitative method of data collection was conducted to assess the quality of family planning services in Jimma Zone primary health centers from March 1<sup>st</sup> -25<sup>th</sup>, 2011. Five Woredas were randomly selected and one public health center from each woreda was randomly selected for this study; then family planning clients were selected using systematic random sampling.

All female family planning clients who visited the family planning clinic during the study period were source population.

Sample size (n) was determined based on the assumption of 50% proportion of satisfied clients, expected margin of error (d) of 0.05 and with 95% confidence level ( $Z_{\alpha/2}$ ) and 10% contingency for non-response. For observation, 150 consultation sessions were observed in the selected five health centers. Study unit at the selected service delivery points were selected using systematic sampling.

Exit interview data were collected through pre-tested structured questionnaire translated into Afan Oromo (the local language). Observation was conducted by trained nurses using checklist. Consultation duration was recorded by observing

the time patients spent in the examination room, from entry to exit.

The quality of data was assured by using validated questionnaires, training of data collectors and supervisors and pre-testing of all the data collection tools on 5% of the study subjects on Jimma Health Center and Jimma Higher 2 Health Center.

After checking the completeness of, and coding of questionnaires, the quantitative data was entered into computer software and analyzed using SPSS version 17.0 for windows.

There were 10 questions on a five point Likert scale with score values ranging from 1 (strongly disagree) to 5 (strongly agree). Principal component analysis was done and three components were identified i.e. perceived sufficiency of consultation (Information given about the method was sufficient & I have had sufficient consultation time), perceived facilitated service (Clinic site is easy to get & Waiting time is not too long) and overall satisfaction (I would come back if I need help again & I would recommend the service friends and relatives) with eigenvalue greater than one. The variance explained and Cronbach's Alpha for each of them respectively was 79%, 80%, 78% and .73, .74 & .71.

Linear and multiple regression analyses were used to assess the relationship between client satisfaction, and the independent variables and significance of the findings was declared at  $p < 0.05$  and the findings were presented in tables and figures.

### Operational definitions

**Quality;** Quality is a multidimensional concept, but in this study, it was measured in terms of client satisfaction and availability of facilities, supplies and instruments for FP service provision.

**Client Satisfaction:** This is clients' opinion of care received from FP services/ staff and is acknowledged as an outcome indicator of quality of care/service. In this study, factor score of the satisfaction scale was used to measure the level of client satisfaction (satisfaction score).

**Waiting time:** Waiting time is the time clients had to wait before receiving their services.

*Acceptable waiting time:*  $\leq 30$  min

➤ *Not acceptable waiting time:*  $> 30$  min

Before field work, ethical clearance was obtained from the Ethical Review Board of the College of Public Health and Medical Science, Jimma University. Jimma Zonal Health Department and the respective woreda health offices were informed in order to get the official letters to conduct the study. Clients who had given verbal consent were interviewed at the end of their visit by trained interviewers who were not members of the clinics' staff. Prior to the observation of the client-provider interaction, both the provider and clients were asked for their willingness to be observed and verbal informed consent was secured from each participant before the commencement of the actual observation. Participants' involvement in the study was on voluntary basis. Participants who were not willing to participate in the study and those who wish to withdraw from the study at any moment were informed to do so without any restriction. Farther more, confidentiality was assured by excluding the names of the clients from any responses.

### RESULTS

**Socio-demographic characteristics:** The majority, 185 (61.5%), of the respondents were from rural areas. Most of them, 285 (94.7%), had discussed on the FP with their husband/partner. Two hundred seventy four (91.0%) of the respondents had children. The mean age of the respondents was  $26 \pm 5$  years old with range between 15-45 years. Nearly half (51.2%) of the family planning service users were either illiterate or read and write only (Table 1).

**Functionality and availability of logistic supplies:** The official working hours for all of the selected health centers from Monday to Friday were 8:30 am to 5:30 pm except for lunch time (12:30 am-1:30 pm). None of the health centers had bill-board or displayed posters about FP in and around the facility campuses. Each of the health centers had two staffs that provided family planning services except one health center which had three staffs that provide the services. All of the providers had in-service training except one provider from Sheki health center.

Table 1: Socio-demographic characteristics of FP clients in Jimma Zone public health centers, Jimma Zone, Southwest Ethiopia, March 2011.

Socio-demographic variables	Frequency( n=301)	%
<b>Age</b>		
15-19	33	10.9
20-24	77	25.6
25-29	102	33.9
30-34	61	20.3
>=35	28	9.3
Mean $\pm$ SD =26 $\pm$ 5, MIN=15 MAX= 45		
<b>Educational status</b>		
Illiterate and read & write only	154	51.1
Primary- secondary	123	40.9
University-college	24	8.0
<b>Religion</b>		
Muslim	236	78.4
Orthodox	53	17.6
Protestant	12	4.0
<b>Ethnicity</b>		
Oromo	253	84.0
Amhara	30	10.0
Others( Yem, Gurage , Tigre and Kefa)	18	6.0
<b>Occupation</b>		
Government t employee	21	7.0
Private employee	35	11.6
Merchant	44	14.6
Unemployed	72	23.9
Housewife	90	29.9
Day laborer	20	6.6
Others*	19	6.3
<b>Marital status</b>		
Married and live together	294	97.7
Others(single, separated & widowed)	7	2.3

\***Others**= commercial sex worker, Farmer

All of the health centers had different IEC materials like flipchart, pamphlets, FP posters, anatomical models, contraceptive samples and leaflets. All of the health centers had no standard FP guideline. All of the health centers had separate rooms for physical examination. The physical examinations rooms were not facilitated within family planning service clinic in Sheki, Shebe, Serbo and Yebu HCs.

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, Mini lap kits, Sterile gloves, Pregnancy test, different contraceptive methods and Minor surgery set.

Blood pressure apparatus, examination bed and stethoscope were shared commonly with other departments like ANC in Serbo, Sheki and Yebu health centers. All of the health centers had recording system for received and dispensed FP commodities and adequate storage facilities.

Every observed health center had mixed old and new client records, daily family planning activity register and monthly FP activity report. Supervision was conducted from higher units for

all HCs. No documented feedback from immediate supervisors and higher units was observed on monthly family planning activity report and supervision.

**Waiting time:** The mean $\pm$ SD waiting time of clients before getting service was 16.4 $\pm$ 18.1 minutes with range of 3 -180 minutes. In general, the waiting time was acceptable (within 30 minute) to 278 (92.4%) of the clients.

**Consultation sessions:** A total of 150 consultation sessions were observed in five health centers, i.e. sessions per health center on average being fifty. Regarding the profile of providers, all except one (male BSc degree holder), were female diploma

nurses and the average service of providers was 1.6 years which ranges from 4 months to 3 years.

The mean consultation duration was 10.5 $\pm$ 8.3 minutes (range=3-50 minutes). In 98 (65.3%) of the cases, the provider greeted the clients in beginning of consultations. In 123(82%) of the observed consultations, the provider informed the clients about modern family planning methods. One hundred and forty (93.3%) of the clients had shown preferences to particular methods.

In all the sessions, the provider told the client at least about one of the FP methods. The most frequently told methods to clients were Norplant 90(60%) and the least frequently raised methods were vasectomy and female sterilization (Table2).

Table 2: Types of FP methods informed to clients during consultation of FP clients in Jimma Zone public health center, Southwest Ethiopia, Jimma Zone, March 2011.

Methods (n=150)	Yes (%)	No (%)
Pills	78(52)	112(74.7)
Condom	32(21.3)	118(78.7)
IUCD	63(42)	87(58.0)
Spermicidal	6(4)	144(96.0)
Female sterilization	5(3.3)	145(96.7)
Vasectomy	5(3.3)	145(96.7)
Natural method	9(6)	141(94.0)
Diaphragm	5(3.3)	145(96.7)
Nor plant	90(60)	60(40.0)
Depo / injectables	38(25.3)	112(74.7)

Particular methods were emphasized in 69 (46%) of the sessions. Depo/Injectables were over emphasized in 42 (28%) of the sessions followed by Pills in 21(14%) of the sessions. On the other

hand, Norplant, UCD and natural methods were infrequently promoted by the providers (Fig 1).

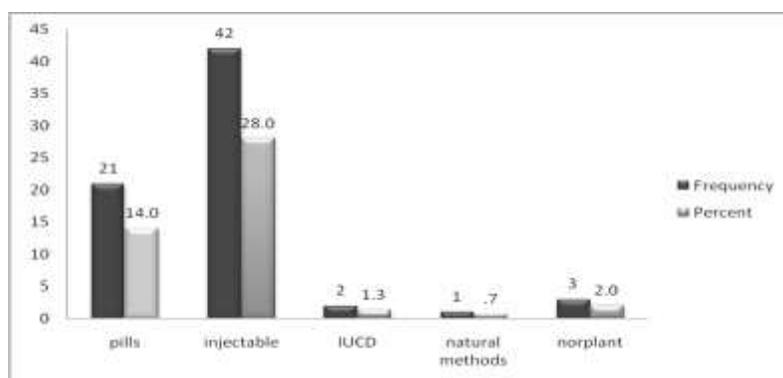


Figure 1: Types of particular contraceptive methods over emphasized by the providers in Jimma in Zone public health centers, March, 2011.

In one-third (33.3%) of the consultation sessions, providers used at least one IEC material. The most frequently used IEC materials during consultation were flip chart (23.3%), displayed sample of contraceptives (26.7%), and posters (16%).

During medical history and physical examinations, the providers asked the history of contraceptive method used 88(58.7%), LMP 113

(75.3%) and unusual vaginal discharge/bleeding 54 (36%) (Table 3). On the other hand, the providers measured blood pressure and weight, conducted physical examinations and prescribed laboratory tests in about 80(53.3%) and 81(54%), 82(54.7%) and 8(5.3%) of the observation sessions respectively.

Table 3: Medical history and physical examination during client provider interaction in Jimma Zone public health centers, March 2011.

Medical history and physical exam.(N=150)	Yes (%)	No (%)
Contraceptive method history	88(58.7)	62(41.3)
Date of LMP	113(75.3)	37(24.7)
Un usual vaginal discharge	54(36)	96(64)
Pelvic pain	44(29.3)	106(70.7)
STDs/STI & HIV	69(46)	81(54)

In two of the pelvic examinations observed, clients were consented, provider washed hands and sterile procedures were followed; however, the outcomes of the examinations were not told. In the same way, in two of IUCD insertion procedures observed, the providers used uterine sound and speculum, followed sterile procedure and emotional support was given. Likewise, out of 150 observations, in 125(83.3%) of the cases the providers administered Depo-Provera; in 100% of the cases the providers used new sterile needle and

syringe, Depo vial was shaken but in 13(10.4%) of the cases the provider massaged injection sites.

Regarding the information given to clients on the chosen contraceptive methods, the providers told to the clients how to use a method, 100 (66.7%), advantages, 80(53.3%), and disadvantages, 76(50.7%), (Table 4).

Other health issues discussed during observation were, abortion, 30(20%), immunization, 53 (35.3%), hypertension, 13 (8.7%), smoking, 6 (4%), and goiter, 4 (2.7%).

Table 4: Information given to clients on the selected method of family planning in Jimma Zone public health centers Jimma zone, March 2011.

Information told about the preferred method (n=150)	Yes (%)	No (%)
How to use method	100 (66.7%)	50(33.3%)
Advantage	80 (53.3%)	70(46.7%)
Disadvantage	76 (50.7%)	74(49.3%)
Side effects	83 (55.3%)	67(44.7%)
Possibility of switching	69 (46.0%)	81(54.0%)
What to do if problem arises	73(48.7%)	77(51.3%)
Where to go for re-supply	81(54.0%)	69(46%)
Is the client told when to return for re supply	125(83.3%)	25(16.7%)

**Client satisfaction with the family planning service:** The overall satisfaction score which was the outcome variable was measured using factor score used in the regression model. The mean score of overall satisfaction was 8.64 (I would come back here if I need help again & I would

recommend the service to friends or relatives) with minimum 2 and maximum 10. Specific to each satisfaction item, the majority of the respondents were satisfied 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%) though about 10.6%, 6.3%, 5.7% and 4% of the

respondents were relatively not satisfied with information sufficiency, adequacy of consultation time, ease of getting clinic site and maintaining privacy respectively (Table5).

Table5: Clients' family planning service satisfaction in public health centers of Jimma zone march 2011.

Statements	Strongly disagree (n/%)	Disagree (n/%)	Uncertain (n/%)	Agree (n/%)	Strongly agree (n/%)
The clinic site is easy to get	6(2.0)	11(3.7)	16(5.3)	166(55.1)	102(33.9)
Waiting time was not too long	4(1.3)	5(1.7)	11(3.7)	186(61.8)	95(31.6)
Clinic hours are convenient	94(0.7)	2(0.7)	5(1.7)	198(65.8)	2(31.2)
Clinic area is clean	3(1.0)	2(0.7)	28(9.3)	126(41.9)	142(47.2)
Information given about the method was sufficient	14(4.7)	18(6.0)	14(4.7)	151(50.2)	104(34.6)
Privacy was maintained	10(3.3)	2(0.7)	9(3.0)	176(58.5)	104(34.6)
I have had sufficient consultation time to discuss about my needs	8(2.7)	11(3.7)	10(3.3)	169(56.1)	103(34.2)
Staff here are really friendly and respectful	3(1.0)	2(0.7)	9(3.0)	173(57.5)	114(37.9)
I would come back here if I need help again	0	0	5(1.7)	189(62.8)	107(35.5)
I would recommend the service to friends and relatives	4(1.3)	0	14(4.7)	166(55.1)	117(38.9)

**Predictors of client satisfaction:** On multiple linear regression analysis, the significant predictors of client satisfaction to family planning services were educational level of the clients, perceived sufficiency of consultation and perceived facilitated service, whereas marital status, tendency to have more children, discussion of FP with husband/partner, occupation of the clients, religion, residence, and age of the clients, and waiting time were not.

As educational level of the clients increases, client satisfaction score to family planning services increases on average by 0.09 (P=0.01(CI:0.02, 0.16)). For a unit increase in perceived sufficiency of consultation, the satisfaction score on average increases by 0.237 at p<0.01 and 95 % CI (0.150-0.291). For a unit increase in perceived facilitated-service, the satisfaction score increases on average by 0.17 at p<0.001, CI (0.09-0.26) (Table 6).

Table 6: Factors predicting the satisfaction of clients on family planning services, Jimma zone public health center, March 2011 Jimma, Ethiopia.

variables	$\beta$	p-value	95.0% CI for $\beta$	
			Lower	Upper
Perceived sufficiency of consultation	0.24	0.000 <sup>**</sup>	0.15	0.29
Perceived facilitated service	0.17	0.000 <sup>**</sup>	0.0.09	0.26
Marital status of clients	-0.430	0.451	-1.550	0.691
Like to have more children	-0.006	0.247	-0.016	0.004
Discussion of FP with husband/partner	-0.135	0.463	-0.496	0.226
Occupation of the clients	0.036	0.092	-0.006	0.078
Religion of the clients	0.006	0.869	-0.068	0.081
Educational level of clients	0.09	0.01 <sup>*</sup>	0.02	0.16
Residence of the clients	0.022	0.820	-0.164	0.208
Ages of the clients	-0.011	0.665	-0.063	0.040
Waiting time	0.003	0.144	-0.001	0.007

<sup>\*\*</sup> Highly Significant predictors <sup>\*</sup> Significant predictors

## DISCUSSION

It has been said that Good quality family planning service helps individuals and couples to meet their reproductive health needs safely and effectively. In this study, an effort has been made to identify information related to quality of family planning service in public health centers of Jimma Zone. It is recognized that this cross-sectional study has possible limitations that may arise from providers who might have shown their best behavioral responses during the observation of client-provider interaction (Hawthorne effect). Moreover, clients might have also shown courtesy bias during the exit interview and introduction of observer bias was also a possibility.

This study identified constraints in family planning clinics in Jimma Zone public health centers related to quality of family planning issues. The long waiting time for clients before getting service is one of the factors affecting the quality of FP resulting in negatively associated with client satisfaction and future client continuity questions (16, 17). In this study, 1.7% of the clients waited for more than one hour with maximum waiting time of 3 hours which is lower than a study report from Limmu Gent Hospital (17.5%) (14). In the current study, about 92.4% of the clients got service within the acceptable waiting time (30minutes). This is by far higher than QIQ MEASURE Evaluation Manual Series, No. 2 and USAID analysis on quality of family planning report from Ghana, Kenya, and Tanzania in which 42.1% and 69% of clients got service within the acceptable waiting time respectively (15, 17). The variation can be because of a difference in facilities, working culture, clients' flow and the recent reform implementation in the setting of current study. The mean consultation time was 10.5 minutes which is almost similar with a study in Northwest Ethiopia 10.1(11), but, three times higher than a study conducted in Jimma Zone in 2003 (14).

This indicates that, in the current study, the provider allowed much more time for clients to express their concerns. This greater discrepancy is probably due to increased client awareness on the importance of getting more information about the existing methods before selecting them and in

availability of FP methods that takes much time for the provider to explain.

Welcoming or greeting clients in the first contact at service delivery points enhances the interaction as it has emotional contents of exchange between provider and clients. Inconsistent with GATHER Model (Greet clients, Ask clients about themselves, Tell clients about FP methods, Help clients choose a Method, Explain how to use method chosen, Refer or return for follow-up) guide of family planning provision in which providers in 100% of the cases should stick to the guideline during consultations, in this study only, 65.3% of the providers greeted their clients, in 82% of the observed interaction, the provider informed the clients about modern family planning and 93.3% of the clients helped to select their preferences to particular methods. This indicates most of the family planning providers are not consistently working as per the guideline which in turn compromises the quality of family planning services. This might be due to provider neglect or shortage of time in because of client over flow.

In most of the observed cases, the providers explained more about Norplant than any other contraceptive methods which might be due to the current trainings rendered on long term contraceptive methods from NGOs side that might make the provider incline to Norplant than the others which was witnessed by provider interview result. Thus, it might negatively affect the success of FP service utilization in those clients who were not informed well.

According to a study done in Northwest Ethiopia, none of the providers used IEC materials except for contraceptive samples in 22% of the observation sessions during consultations (12). However, in the current study, one-third of the family planning providers used at least one IEC material during consultations.

In the current study, client-provider interaction during medical history recording is by far better than study findings in Northwest Ethiopia in which about 98.5% of the clients were not asked about STD risk (12). This great discrepancy can be attributed to variation in the time of study, the growing emphasis on giving customized services as a result of business process re-engineering implementations and providers' experience.

Important indicators of the technical quality of care include providers' compliance to acceptable clinical practice of FP and reproductive service delivery guideline, as well as complete and accurate knowledge of methods, physical examination and reproductive health care (10). In this study, the information given to clients on the chosen contraceptive methods, the providers told to the clients about side effects (55.3%), possibility of switching (46%), where to go for resupply (54%), and clients were told when to return for resupply with written reminders (83.3%). However, in a considerable number of observations, a big number of clients did not get information that may help them in the achievement of their fertility goals. This shows that providers are not consistently complying with guideline recommendations in giving information to clients about the selected methods.

The guideline of FP services in Ethiopia recommends that a minimum of 4 trained FP service providers are required in a health center. Despite this, four of the five health centers in this study had only 2 trained FP service providers which were similar to what was reported by earlier workers (11, 12, 13). Similarly, the providers claimed that the main factors relating to the quality of family planning services provision are lack of adequate number of in-service trained staff, lack of family planning guideline, shortage of emergency contraceptives, shortage of medical equipment, privacy issue, lack of sufficient ICE materials, client's awareness level on FP and provider's competency. This is scientifically supported as it is stated in FP guideline and different family planning quality studies.

The health facilities were functional throughout the working days, 8 hrs per day, in accordance with the country's civil servant regulation. The average time at which service delivery process began after official opening hour was 33 minutes. These delays were due to time taken to deliver health information but it might dissatisfy the clients who came early in the morning.

The guideline of FP services of the MOH in Ethiopia is supposed to be used at all levels of SDPs. However, it was found out in this study that none of the health centers had national and international FP guidelines. It is obvious that in the absence of the guideline, implementation of

the stated objectives and principles for the betterment of quality would be difficult.

The mean overall satisfaction score was 8.64 and 93.7% of the clients were satisfied in the family planning services they were provided with. This is higher than the satisfaction report from Sirilanka, Colombo District 80.8 % (14) and Iran, 61.3 %, (15). The probable reasons for the discrepancy between the two studies might be socio-demographic differences between the two study populations. Perceived sufficiency of consultation, perceived facilitated service ( $\beta=0.17$ ) and educational level of clients ( $\beta=0.09$ ) were significantly associated with overall satisfaction score.

In conclusion, most of the family planning clinics had no adequate equipment and supplies for family planning services; most of them share BP apparatus and stethoscope with other departments. Family planning service providers were not complying with the guideline and none of the family planning clinics had enough number of trained staff as per the MOH family planning guideline. Most clients, nine in ten of them, were served within 30 minutes but utilization of IEC material during consultation was very low (33.3%). Providers did not assess critical information in more than half of the observed consultation sessions. The overall satisfaction was 8.64 and the predictors of satisfaction to family planning were: sufficient consultation time, adequate information on the chosen method of family planning and educational level of clients. Jimma Zone Health Department, woreda health offices and health managers of the facilities have to consider ways of improving availability of supplies and equipment, trained personnel and IEC materials at the family planning clinics of the primary health care centers.

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## REFERENCES

1. Bruce J. Implementing the user perspective. *Studies in Family Planning* 1980; 11: 29-33.

2. Jain AK. Fertility reduction and the quality of family planning services. *Studies in Family Planning* 1989; 20: 1-16.
3. International journal of quality in health care 2003; volume15, number4; pp 357- 358.
4. Wako G, Berhane Y. Structural quality of reproductive health services in South-Central Ethiopia. *Ethiop. J. Health Dev.* 2000; 14(0):317-325.
5. USAIDS. Client-Provider Interactions in Family Planning Services: Guidance from Research and Program Experience, maximizing access and quality Paper. Vol.1, No2, 2000.
6. Carol S. et al : Quality Management in Public and Community Health: Examples from Women's Health.
7. Donabedian, A. The quality of care: How can it be assessed? *Journal of American medical association* 260 (12): 1743-1748, Sep 23-30, 1988.
8. Davida Becker, Ann C. Klassen, Michael A. Koenig and Thomas A. LaVeist. Women's Perspectives on Family Planning Service Quality: An Exploration of Differences by Race, Ethnicity and Language. *Perspectives on Sexual and Reproductive Health.* Volume 41, Number 3, September 2009.
9. WHO. Reduction of Maternal Mortality. A Joint WHO/UNFPA/UNICEF/World Bank Statement. Geneva; 1999:20-33.
10. Agwanda, Alfred, Anne Khasakhala, and Maureen Kimani. 2009. Assessment of Family Planning Services in Kenya: Evidence from the 2004 Kenya Service Provision Assessment Survey: Kenya Working Papers No. 4. January 2009.
11. Frameworks for improving quality of services have common features, including a client emphasis. *Network*: Fall 1998, Vol. 19, No. 1.
12. Fantahun M. Quality of family planning services in Northwest Ethiopia. *Ethiopia J. Health Dev.* 2005;19(3):195-20.
13. Asfaw Y. Assessment of quality of care in family planning service in AA, *Ethiop. J. Health Dev.* 2000;14(0):317-325.
14. Loha. E, Asefa M, J .Chali, T.Fasil. Assessment of quality of care in F/P service in Jima Zone: 2003. *Ethiop.J.Health Dev.* 2003; 18(1):8-18].
15. Simbar M, Ahmad M, and Ahmadi G. Quality assessment; Birth control; Customer satisfaction; Individual perception; Iran. *International Journal of Health Care Quality Assurance.* 2000, Vol.19, no5:430-442.
16. *Quick Investigation of Quality (QIQ): A User's Guide for Monitoring Quality of Care in Family Planning; MEASURE Evaluation Manual Series, No. 2 February 2001;*
17. Singh S, Darroch JE, Vlassof M, Nadeau J. *Adding It Up: The Benefits of Investing in Sexual and Reproductive Health Care.* New York: Alan Guttmacher Institute; 2003. Available at: [www.guttmacher.org/pubs/addingitup.pdf](http://www.guttmacher.org/pubs/addingitup.pdf). accessed on December 2,2010.
18. .United Nations (UN 2007). The Millennium Development Goals Report. UN, New York, 2007.
19. UN report of international conference on population and development (ICPD), New York, 1995.
20. Rhonda Smith, Lori Ashford and Jay Gribble Donna Clifton, *Family planning saves life* 4<sup>th</sup> edition PP5-8.
21. Donabedian A. The definition of quality and approaches to its assessment, 1980; Vol II.
22. Federal Democratic Republic of Ethiopia population census commission. Summary and statistical report of the 2007 Population and housing census of Ethiopia. Addis Ababa December 2008.
23. The Transitional Government of Ethiopian. The national population policy office of the prime minister. Addis Ababa, June 1993.
24. The Transitional Government of Ethiopian. The national health policy office of the prime minister. Addis Ababa, May, 1993.
25. Jimma zonal health department second quarter activity achievement report of 2003 EC.