Respectful family planning service provision in Sidama zone, Southern Ethiopia

CURRENT STATUS: POSTED

Melese Siyoum
Hawassa University College of Medicine and Health Sciences
melesesiyoum755@gmail.com Corresponding Author
ORCiD: 0000-0001-5451-5665

Ayalew Astatkie
Hawassa University College of Medicine and Health Sciences

Teshome Melese
Hawassa University College of Medicine and Health Sciences

Zelalem Tenaw
Hawassa University College of Medicine and Health Sciences

Abebaw Abeje
Hawassa University College of Medicine and Health Sciences

Lee Roosevelt

DOI:
10.21203/rs.2.13674/v1

SUBJECT AREAS
Health Economics & Outcomes Research Health Policy

KEYWORDS
family planning, respectful care, abuse, disrespect, contraceptives, Ethiopia
Abstract

Introduction Disrespect and abusive care is a violation of women’s basic human rights and it is serious global problem that needs urgent intervention. In Ethiopia disrespect and abusive care is very common (21-78%) across health facilities. Objective To assess the status of respectful family planning service in Sidama zone, south Ethiopia. Methodology Health facility-based cross-sectional study was conducted from June to August 2018. Data were collected from 920 family planning clients’ recruited from 40 randomly selected health facilities. The Mother on Respect index (MORi) questionnaire was used to collect the data through client exit interview. Partial proportional odds ordinal regression was employed to identify determinants of respectful family planning service. Result The level of respectful family planning service was found to be: Zero (0%) in the very low respect category, 75(18.5%) low respect, 382(41.52%) moderate respect and 463(50.33%) high respect. Being a short acting method client (AOR=0.3, 95%CI [0.12, 0.72]), participants’ level of education (uneducated (AOR=0.39, 95%CI [0.25, 0.61), elementary (AOR=0.41, 95%CI [0.23, 0.73]), low income(AOR=0.75, 95%CI [0.56, 0.99]), long waiting time (AOR=0.46, 95%CI [0.30, 0.69]), were negatively associated with moderate and high respect compared to low respect. Preference of male service providers (AOR=2, 95%CI [1.1, 3.8]), service providers’ work satisfaction (AOR=1.55, 95%CI [1.13, 2.14]) and health workers’ prior training on respectful care (AOR=8.75, 95%CI [4.61, 16.61]) were positively associated. Being a client of short acting contraceptives (AOR=2.1, 95%CI [1.42, 3.12]), preference of male service providers (AOR=0.55, 95%CI [0.4, 0.76]) and health workers’ prior training on respectful care (AOR=3.03, 95%CI [2.24, 4.1]) had significant association with high respect compared to low and moderate respect. Conclusion Considering the current strategy of zero tolerance for disrespect in Ethiopia, the level of respectful care in this study is sub-optimal. We recommend community awareness and short term training
for service providers.

Background

Respectful maternity care (RMC) is an individual (client) centered approach, which is based on principles of ethics and respect for human rights and women’s needs and preferences(1).

There are many evidence based definitions of disrespectful maternity care (2–8). The most commonly used definition is identified by Bowser and Hill (2010), which includes physical abuse, non-consented care, non-confidential care, non-dignified care, discrimination, abandonment of care and detention in health facility (6, 9–14). Disrespect and abuse of service seeking women is an urgent problem that needs the concern of all stake holders including health care research, quality and education, human rights and civil rights advocacy throughout the entire world (4).

A growing body of evidence shows that disrespect and abuse during maternity care is becoming an increasing problem worldwide (4, 8, 10, 11, 15). A cross sectional study conducted in Nigeria showed that 98% of childbearing mothers had faced at least one category of disrespect (16). A systematic review conducted in the same country on the same topic revealed that disrespect during child birth is common and the most frequent category of disrespect was non-dignified care (11.3% to 70.8% across the health facilities(17). In Tanzania 70% of respondents were disrespected; where non-consented care was reported in 50% of participants (13).

In Ethiopia, 78% of women who gave birth at health facility in Addis Ababa experienced one or more category of disrespect where the right of information like self-introduction and consent is violated in 94% cases (18). It is common to see disrespect and abusive care at the point of client-provider interaction (3, 5, 12, 15, 19). In addition to the high prevalence of disrespect and abusive care worldwide, it is neglected and even normalized
in many areas (8, 10, 17, 20, 21). For instance among 78.6% of participants who were disrespected based on observational checklist in Addis Ababa during child birth, only 22% of them considered it disrespectful care(18).

Lack of respectful maternity care (RMC) constitutes a barrier to the use of health service utilization and also it affects the basic human dignity and human rights (6, 17, 20, 22-24). Disrespectful and abusive behavior tends to be higher among women identified as having low socioeconomic status, lower educational attainment. Disrespectful care is also higher when there are weak health care systems, poor managerial systems, provider demotivation, lack of equipment and supplies, weak or non-existing legal system (6, 17, 20, 22-24).

Despite the continued prevalence of the problem there is good evidence that interventions, such as health care provider training and community mobilization, have a positive impact on the promotion of respectful maternity care (3, 16, 18, 20, 21). To overcome the problem of disrespectful and abusive care in Ethiopia, L10K and the Ethiopian Midwives Association have been providing training for higher institution instructors and obstetric care providers who are working in the labor and delivery ward (15, 25). The Ministry of Health has also started to provide training for all health care workers since March 2017. However, family planning units where respectful care is highly needed as women need correct and accurate information, privacy and confidentiality, respect for her choice of method, dignity and free from physical abuse, is still neglected.

In Ethiopia the contraceptive prevalence rate is low (36%) for married women. There is also low uptake of long acting methods(26), high discontinuation rate of long acting methods and poor counseling services (27), all of which could be related to lack of respectful care, yet there is lack of evidence on the level of respectful care for family planning service users in Ethiopia. Therefore, this study aimed to assess the level of
respectful family planning services and its determinants in Sidama Zone, southern Ethiopia.

Methods And Materials

This study was a health facility-based, cross sectional study conducted in Sidama zone, Southern region of Ethiopia from June 29 to July 20/2018. Hawassa, the capital city of the Southern Nations, Nationalities and Peoples Region and Sidama Zone, 273 kms south of Addis Ababa, the capital of Ethiopia. The zone is situated in the southern region of the country and has 19 districts and 3 town administrations. According to a report from Sidama Zone Health Department, the total population of Sidama zone is estimated to be 5,499,683 and 85,341 women of reproductive age. There are three governmental hospitals, 130 health centers and 522 health posts providing family planning services. The overall contraceptive coverages of south region and Sidama Zone are 39.9% and 13% respectively(28).

Sample size and sampling technique: The sample size was determined using double population proportion formula using Open Epi version 2.3 with the assumptions of 95% confidence level, power 80%, unexposed-to-exposed ratio of one and proportion of cases among exposed (respectful care by trained service providers) 87% (2). Accordingly a sample size of 940 was calculated and proportionally allocated to the health facilities included in the study based on number of clients flow for three months preceding the data collection time. Accordingly, systematic random sampling was used to select every either client who visited family planning units for contraceptive use, and all family planning service providers of the 40 health facilities were included.

Data collection tools and techniques

Data were collected through client exit interview using questionnaire adapted from the Mothers on Respect index (MORi) questionnaire (29). The MORi questionnaire was
developed to assess the client provider interaction and their impact on personal sense of respect. Bohren et al., who developed the most commonly used tool for measuring disrespect and abusive care at health facility, have recommended to develop new validated and reliable tool. Accordingly MORi questionnaire is developed through a participatory research process in Canada and USA and the tool was found to be valid and reliable. The tool has 14 items with six response scale (ranges from strongly disagree to strongly agree). Very few words were modified in to family planning context and used directly in this data collection process after translated in to local languages (Amharic and Sidaamu Afoo). Data were collected through face to face interview with contraceptive user mothers at exit time. Self-administered questionnaire was used to collect data from service providers to assess service provider related factors affecting respectful family planning service. Service providers were given a code blindly when they provide family planning service and after all mothers were interviewed, data were collected from service providers and linked to maternal data based on the code provided.

Operational definitions

Based on the result of Mother on Respect index (MORi), participant respectful care is classified as: very low Respect if the client scores 14—31, low Respect if the client scores 32—49, Moderate Respect if the client scores 50—66 and high Respect if the client scores 67—84.

Data processing and analysis

All quantitative data were checked for completeness, coded and entered in to Epi Data version 3.1 and exported to Stata version 13 for analysis. Frequencies, Mean, standard deviation and proportions were calculated for descriptive data and the results were presented by tables and charts. To identify factors associated with the level of respectful family planning service, a partial proportional odds ordinal regression was employed using
the `gologit2` command of Stata, since some of the variables violated the proportional odds assumption (30).

Ethical clearance was obtained from the Institutional Review Board of Hawassa University and communicated with Sidama zone health department and the selected woredas. A formal letter was obtained from the woredas and communicated with selected health institutions. After the purpose and objective of the study was explained, consent was obtained from each study participant.

Results

Socio-demographic characteristics

A total of 920 individuals from 40 health facilities participated in the study making a response rate of 97.9%. The minimum and maximum ages of the participants were 14 and 46 years respectively with a mean and standard deviation (±SD) of 27.19 ± 5.42 years. Among the participants 905 (98.37%) were married, 830 (90.22%) were Sidama in Ethnicity, 783 (85.11%) were protestant, 453 (49.24%) had an elementary school education, 633 (68.8%) identified as housewives and their average annual income ranges from Zero to 600,000 ETB (equivalent to $21,428.57) with a mean of 26144.3 ETB (equivalent to $933.73). The maximum number of family size, gravidity and parity of the participants were 11, 13 and nine respectively [see Table 1].

Characteristics of the current service provided

Among the participants, 625 (67.93%) had visited the specific health facility three or more times for family planning service while 137 were first time clients. At the time of the study, 708 (76.96%) of the participants used injectable contraceptive. Waiting time for 766 (83.26%) of the study participants was less than 30 minute. Two hundred eighty five (30.98%) of the participants preferred to get served by males [see table 2].

Characteristics of the current service providers
A total of 66 family planning service providers from 40 health facilities participated in this study. The age of the service providers ranged from 22 to 58 years with a mean and standard deviation of 28.65 ± 5.9 years. Among the service providers who participated in the study, 47 (71.2%) were females, 49 (74.2%) were married, 43 (65.2%) were protestant. Service provider’s year of experience ranges from one to 30 years whereby 65 (98.1%) of them worked less than 5 years and their monthly salary ranged from 2181 ($77.89) to 9000 Ethiopian birr ($321.43) [see table 3].

Overall Respectful Family Planning Service

In this study almost half of the participants reported that they were highly respected during family planning service utilization and no one reported receiving very low respect.

Figure 1: Pie Chart showing level of Respectful family planning Service in Sidama zone, Ethiopia, 2018

Factors Associated with Respectful Family Planning Service

In the unadjusted partial proportional odds model, age of the client, place of residence, type of method used (short acting method), clients level of education, average annual income, gravidity, waiting time, duration of procedure, sex of service providers’, training of service providers, preference of opposite sex of provider and service providers satisfaction were associated with respectful family planning service at the P-values of < 0.2.

After adjustment using multivariable partial proportional odds model, type of contraceptive used, participants level of education, average annual income, preference for male service providers, service providers’ satisfaction and prior training on respectful care were significantly associated with respectful family planning service [see Table 4].

Discussion

Our finding showed that 18.5% of the family planning service users received low level of
respect during family planning service provision, 41.5% received moderate respect and
50.3% received high level of respect. This is low compared to the current Ethiopian
government strategy which states “zero” tolerance for disrespect and abuse (31).
The odds of being in the next higher category or above of respectful care for women who
were not educated is 61% lesser relative to women who completed at least secondary
school, and the odds of being in the moderate or high category of respectful care relative
to being in the low category is 59% lesser for women who attended elementary school
compared to those who completed at least secondary school. However, there was no
significant difference between the odds of being in the high respectful care category
relative to being in the low and moderate category for women who attend elementary
school compared to those who completed at least secondary school. This is supported by
systematic review conducted in Nigeria which reported that, disrespect and abuse during
child birth was more common among women who were uneducated and of low
socioeconomic status (17). Educated women are better aware of their rights reducing the
likelihood of being disrespected. From this study, we understand that higher level of
education, (secondary school and above), protect females from low respect; even though
this alone could not yield high respect category.
The odds of being in the moderate or high category of respectful care relative to being in
the low category is 25% lesser for women who were under poverty line (whose average
daily income is less than $1.25) compared to those who were above poverty line. This is
supported by study conducted in Bahir-Dar and Addis Ababa where poor women were
found to be more abused and disrespected during child birth (18, 32). Low socio-economic
status leads women to seek services in low-quality facilities where women are prone to be
disrespected and abused (10).
Even though there is no significant difference between odds of being in the moderate or
high category of respectful care relative to being in the low category for women who wait more than 30 minutes compared to those who wait less than 30 minutes, the odds of being in the high respectful care category relative to being in the low and moderate category is 54% lesser for women who wait long (more than 30 minutes). Long waiting time may discourage clients and lead them to feel that they are neglected and not respected. In similar studies, long waiting time to contact a service provider was found to be associated with dissatisfaction of family planning service (33, 34).

The odds of being in the moderate or high category of respectful care relative to being in the low category is 70% lesser for women who use short acting contraceptives compared to those who use long acting methods, whereas the odds of being in the high respectful care category relative to being in the low and moderate category is two times higher for women who use short acting methods compared to those using long acting methods. One of the priority areas of the Ethiopian government implementation plan from 2016 to 2020 is to increase long acting reversible contraceptive mainly IUCD from 1.1% to 8.25% and implant from 5% to 18.15% (35). This strategy may influence service providers to push and enforce clients to take long acting family planning method, so that clients who prefer short acting methods may be abused and disrespected. On the other hand, the odds of being in the high respectful care category relative to being in the low and moderate category is higher for short acting method users. This could be due to long procedural time for long acting method insertion. In this study, some clients complained that the procedure for IUCD insertion takes around 50 minutes.

The odds of being in the next higher category or above of respectful family planning service for clients served by health care workers who were satisfied with their current status is 1.6 times higher relative to those served by health workers who were not satisfied. This is supported with a mapping review and gender analysis study which
reports that lack of respect for health care workers and limited training opportunities erode their ability to deliver high quality care (36). Provider emotional health has the potential to drive mistreatment and affect women’s care (37).

The odds of being in the moderate or high category of respectful care relative to being in the low category is two times higher for women who prefer male service providers compared to those who did not prefer males, whereas the odds of being in the high respectful care category relative to being in the low and moderate category is 45% lesser for women who prefer male service providers compared to those who did not prefer males. This might occur when those women who prefer male providers are individuals who need more respect for themselves, need attention and may have good socio-economic status. Secondly, it could be due to cultural expectations that males are more respectful and caring for females than the female service providers do. In current study, since 76% of clients got service from female providers, those who prefer male providers may undermine the respectful service provided.

The odds of being in the moderate or high category of respectful care relative to being in the low category is almost nine times higher for women who received service from trained providers (on respectful care) compared to those who received service from untrained providers, whereas the odds of being in the high respectful care category relative to being in the low and moderate category is three times higher for women who received service from trained providers compared to those who received service from untrained providers. The training program had a positive impact on the quality of counseling family planning services, providers’ interpersonal skills and overall knowledge (38). This is supported by a pilot study training reproductive health care nurses on promoting respectful maternity care which concluded that the training has positive impact on promoting respectful care (39).
This study has strengths relative to previous studies. One of the strength is that this study may be the first to conduct analytical study in Ethiopia using the current validated tool on respectful care. Again it may be the first to assess respectful family planning service (previous studies focus on childbirth).

This study is not free of limitations. The tool is new and may be difficult for uneducated women to identify the difference of possible options for answers, so that it may introduce response bias.

Conclusion

The respectful family planning service in this study is poor, as the current strategy allows zero tolerance for disrespect. Type of contraceptive used, participant’s lower level of education, low average annual income, long waiting time, preference for male service providers, service providers’ satisfaction and service providers’ prior training on respectful care were significantly associated with respectful family planning service. However, the effect of the identified variables across each level of respectful care is not equal. Strengthening training on compassionate and respectful care is mandatory to improve respectful care at all health institutions.

Declarations

Acknowledgement

We want to thank Center of International Reproductive Health Training, Ethiopia branch for the initiation, training and promise to support us throughout the process of this research. Our great thank goes to Mr. Habtamu Kebebe (Wollega University) for his comment during the development of this proposal.

Availability of data and materials

The dataset analyzed is included in the main document.

Authors’ contributions
MS conceived the study, MS and AA designed the study, analyzed and interpreted the data; and drafted the manuscript. AA, TM and ZT designed the research supervised the overall process of the research. All authors critically reviewed the manuscript and approved the final manuscript.

**Ethics approval and consent to participate**

The study was approved by the IRB of College of Medicine and Health Sciences, Hawassa University. Data were collected after taking informed consent from the mothers.

**Funding**

This study was supported by Center for International Reproductive Health Training (CIRHT), Ethiopia.

**Consent for publication**

Not applicable.

**Competing interests**

The authors declare that they have no competing interests.

**References**

1. Reis V, Deller B, Carr C, Smith J. Respectful maternity care: country experiences. Washington DC: MCHIP/USAID. 2012;3.

2. Abuya T, Ndwiga C, Ritter J, Kanya L, Bellows B, Binkin N, et al. The effect of a multi-component intervention on disrespect and abuse during childbirth in Kenya. BMC pregnancy and childbirth. 2015;15(1):224.

3. Abuya T, Warren CE, Miller N, Njuki R, Ndwiga C, Maranga A, et al. Exploring the prevalence of disrespect and abuse during childbirth in Kenya. PLoS One. 2015;10(4):e0123606.

4. Alliance WR. Respectful maternity care: the universal rights of childbearing women. White Ribbon Alliance. 2011.
5. Bohren MA, Vogel JP, Hunter EC, Lutsiv O, Makh SK, Souza JP, et al. The mistreatment of women during childbirth in health facilities globally: a mixed-methods systematic review. PLoS Medicine. 2015;12(6):e1001847.

6. Bowser D, Hill K. Exploring evidence for disrespect and abuse in facility-based childbirth. Boston: USAID-TRACTION Project, Harvard School of Public Health. 2010.

7. Vogel J, Bohren M, Tunçalp Ö, Oladapo O, Gülmezoglu A. Promoting respect and preventing mistreatment during childbirth. BJOG: An International Journal of Obstetrics & Gynaecology. 2015.

8. World Health Organization W. The prevention and elimination of disrespect and abuse during facility-based childbirth: WHO statement. 2014.

9. Moyer CA, Rominski S, Nakua EK, Dzomeku VM, Agyei-Baffour P, Lori JR. Exposure to disrespectful patient care during training: Data from midwifery students at 15 midwifery schools in Ghana. Midwifery. 2016;41:39–44.

10. Ndwiga, Charity, Charlotte Warren, Timothy Abuya, Lucy Kanya, Alice Maranga, et al. Respectful Maternity Care Resource Package; Community Facilitator’s Guide,. New York, Population. 2014.

11. Reis V, Deller B, Carr C, Smith J. Respectful maternity care: country experiences. 2012.

12. Rosen HE, Lynam PF, Carr C, Reis V, Ricca J, Bazant ES, et al. Direct observation of respectful maternity care in five countries: a cross-sectional study of health facilities in East and Southern Africa. BMC Pregnancy Childbirth. 2015;15:306.

13. Sando D, Ratcliffe H, McDonald K, Spiegelman D, Lyatuu G, Mwanyika-Sando M, et al. The prevalence of disrespect and abuse during facility-based childbirth in urban Tanzania. BMC Pregnancy Childbirth. 2016;16:236.

14. Warren C, Njuki R, Abuya T, Ndwiga C, Maingi G, Serwanga J, et al. Study protocol for promoting respectful maternity care initiative to assess, measure and design interventions
to reduce disrespect and abuse during childbirth in Kenya. BMC Pregnancy and Childbirth. 2013;13(1):21.

15. L10K. Assessment of disrespect & abuse during childbirth in two regions of Ethiopia: A qualitative study in four PHCUs (Kebet, Lante, Deneba and Denbecha) 2014.

16. Okafor II, Ugwu EO, Obi SN. Disrespect and abuse during facility-based childbirth in a low-income country. International Journal of Gynecology & Obstetrics. 2015;128(2):110-3.

17. Ishola F, Owolabi O, Filippi V. Disrespect and abuse of women during childbirth in Nigeria: A systematic review. PLoS One. 2017;12(3):e0174084.

18. Asefa A, Bekele D. Status of respectful and non-abusive care during facility-based childbirth in a hospital and health centers in Addis Ababa, Ethiopia. Reproductive health. 2015;12:33.

19. Mannava P, Durrant K, Fisher J, Chersich M, Luchters S. Attitudes and behaviours of maternal health care providers in interactions with clients: a systematic review. Globalization and health. 2015;11:36.

20. Ratcliffe H. Creating an Evidence Base for the Promotion of Respectful Maternity Care. Boston, MA: Harvard School of Public Health. 2013.

21. Team TTMCV, Carter MC, Corry M, Delbanco S, Foster TC-S, Friedland R, et al. 2020 vision for a high-quality, high-value maternity care system. Women’s health issues. 2010;20(1):S7-S17.

22. Birmeta K, Dibaba Y, Woldeyohannes D. Determinants of maternal health care utilization in Holeta town, central Ethiopia. BMC health services research. 2013;13(1):256.

23. Kruk ME, Kujawski S, Mbaruku G, Ramsey K, Moyo W, Disrespectful LPF. Evidence and recommendations submitted to the iERG by White Ribbon Alliance on behalf of members of the Global Respectful Maternity Care Community of Concern. 2015.

24. Warren CE, Njue R, Ndewiga C, Abuya T. Manifestations and drivers of mistreatment of
women during childbirth in Kenya: implications for measurement and developing interventions. BMC Pregnancy Childbirth. 2017;17(1):102.

25. Federal Ministry of Health F. Respectful Maternity Care and Partograph Training Resource Package Participant manual Addis Ababa, Ethiopia 2015.

26. Central Statistical Agency C, ICF. Ethiopia Demographic and Health Survey 2016: Key Indicators Report. Addis Ababa, Ethiopia, and Rockville, Maryland, USA. CSA and ICF: 2016.

27. KALAYU B. EARLY DISCONTINUATION RATE OF IMPLANON AND ITS ASSOCIATED FACTORS AMONG WOMEN WHO EVER USED IMPLANON IN 2012/2013 IN OFLA WOREDA, TIGRAY, NORTHERN ETHIOPIA, 2014: AAU; 2014.

28. ICF CSACEa. Ethiopia Demographic and Health Survey 2016: Key Indicators Report. Addis Ababa, Ethiopia, and Rockville, Maryland, USA.: CSA and ICF, 2016.

29. Vedam S, Stoll K, Rubashkin N, Martin K, Miller-Vedam Z, Hayes-Klein H, et al. The mothers on respect (MOR) index: measuring quality, safety, and human rights in childbirth. SSM-population health. 2017;3:201-10.

30. David Garson G., Publishing SA. ordinal regression www.statisticalassocites.com; 2014.

31. FMoH. National Compassionate, Respectful and Caring Health Workforce training In: Health Mo, editor. Addis Abeba 2017.

32. Biresaw W., Z. S. Compassionate and Respectful maternity care during facility based child birth and women’s intent to use maternity service in Bahir Dar, Ethiopia. Addis Ababa, Ethiopia: Addis Ababa; 2017.

33. Savul S, Naeem Z, Naseem S. Satisfaction of Female Patients with Health Care Services at the Peri-urban Community Health Centre in Islamabad. Cureus. 2018;10(8):e3101.

34. Tafese F, Woldie M, Megerssa B. Quality of family planning services in primary health centers of Jimma Zone, Southwest Ethiopia. Ethiopian journal of health sciences.
35. (FMoH) EFMoH. COSTED IMPLEMENTATION PLAN FOR FAMILY PLANNING IN ETHIOPIA, 2015/16-2020. Addis Ababa 2016.

36. Betron ML, McClair TL, Currie S, Banerjee J. Expanding the agenda for addressing mistreatment in maternity care: a mapping review and gender analysis. Reproductive health. 2018;15(1):143.

37. Ndwiga C, Warren CE, Ritter J, Sripad P, Abuya T. Exploring provider perspectives on respectful maternity care in Kenya: “Work with what you have”. Reproductive health. 2017;14(1):99.

38. Ugaz J, Leegwater A, Chatterji M, Johnson D, Baruwa S, Toriola M, et al. Impact of Family Planning and Business Trainings on Private-Sector Health Care Providers in Nigeria. International perspectives on sexual and reproductive health. 2017;43(2):51-65.

39. Webber G, Chirangi B, Magatti N. Promoting respectful maternity care in rural Tanzania: nurses’ experiences of the “Health Workers for Change” program. BMC Health Serv Res. 2018;18(1):658.

Tables

Table 1: Socio-demographic characteristics of study participants on Respectful family planning service in Sidama Zone, southern Ethiopia, 2018.
| Variables          | Category          | Frequency (N=920) | Percentage |
|--------------------|-------------------|-------------------|------------|
| **Age**            | 14-24             | 289               | 31.41      |
|                    | 25-29             | 322               | 35.00      |
|                    | 30 and above      | 309               | 33.59      |
| **Marital status** | Single            | 8                 | 0.87       |
|                    | Married           | 905               | 98.37      |
|                    | Divorced/widowed  | 7                 | 0.77       |
| **Religion**       | Protestant        | 783               | 85.11      |
|                    | Orthodox          | 53                | 5.77       |
|                    | Muslim            | 33                | 3.57       |
|                    | Catholic          | 24                | 2.67       |
|                    | Adventist         | 27                | 2.97       |
| **Ethnicity**      | Sidama            | 830               | 90.22      |
|                    | Amhara            | 45                | 4.87       |
|                    | Oromo             | 13                | 1.47       |
|                    | Others\(^a\)      | 32                | 3.47       |
| **Residence**      | Urban             | 273               | 29.67      |
|                    | Rural             | 647               | 70.33      |
| **Level of education** | no formal education | 271               | 29.00      |
|                    | Primary (1-8)     | 453               | 49.00      |
|                    | Secondary School (9-10-) | 152               | 16.38      |
|                    | Above high school (>10) | 44               | 4.78       |
| **Gravidity**      | Two or less       | 506               | 55.00      |
|                    | Three and above   | 414               | 45.00      |
| **Parity**         | Two or less       | 485               | 52.00      |
|                    | Three and above   | 435               | 47.00      |
| **Occupation**     | House wife        | 633               | 68.00      |
|                    | Employed(government/NGO) | 54              | 5.80       |
|                    | Private business  | 152               | 16.00      |
|                    | Student           | 67                | 7.20       |
|                    | Other\(^b\)       | 14                | 1.50       |
| **Annual Income Category** | Under poverty | 465               | 50.00      |
|                    | Above poverty     | 455               | 49.00      |

\(^a\) Wolayta, Gurage, Tigre, Silte

Table 2: Characteristics of service provided for study participants on Respectful family planning service in Sidama Zone, southern Ethiopia, 2018.
| Variables                          | Category              | Frequency (n=920) | Percentage |
|-----------------------------------|-----------------------|-------------------|------------|
| Frequency of FP unit Visit        | once                  | 137               | 14.89      |
|                                   | Twice                 | 158               | 17.17      |
|                                   | Three and above       | 625               | 67.93      |
| Method Used                       | Pills                 | 247               | 5.11       |
|                                   | Injectable             | 708               | 76.96      |
|                                   | Implant               | 146               | 15.87      |
|                                   | IUCD                  | 18                | 1.96       |
|                                   | Condom                | 1                 | 0.11       |
| Waiting time                      | ≤30 minute            | 766               | 83.26      |
|                                   | >30 minute            | 154               | 16.74      |
| Duration of the procedure         | ≤10 minute            | 757               | 82.28      |
|                                   | >10 minute            | 163               | 17.72      |
| Number of Service providers       | One                   | 615               | 66.85      |
|                                   | Two and above         | 305               | 33.15      |
| Sex of service providers          | Male                  | 221               | 24.02      |
|                                   | Female                | 699               | 75.98      |
| Prefer opposite sex?              | No                    | 635               | 69.02      |
|                                   | Yes                   | 285               | 30.98      |
| Provider introduced his name?     | No                    | 745               | 80.98      |
|                                   | Yes                   | 175               | 19.02      |
| Provider introduced his role       | No                    | 778               | 84.57      |
|                                   | Yes                   | 142               | 15.43      |
| Involved in decision making       | No                    | 267               | 29.02      |
|                                   | Yes                   | 653               | 70.98      |
| Client called by her name         | No                    | 358               | 38.91      |
|                                   | Yes                   | 562               | 61.09      |

Table 3: Characteristics of service provider on Respectful family planning service in Sidama Zone, southern Ethiopia, 2018.

| Variables       | Category | Frequency (N=920) | Percentage |
|-----------------|----------|-------------------|------------|
| Age             | 22-30 years | 52               | 78.8       |
| Category                      | Option    | Count | Percentage |
|-------------------------------|-----------|-------|------------|
| Age                           | 31 and above | 14    | 21.2       |
| Sex                           | Male      | 19    | 28.8       |
|                               | Female    | 47    | 71.2       |
| Marital status                | Single    | 17    | 25.8       |
|                               | Married   | 49    | 74.27      |
| Religion                      | Orthodox  | 20    | 30.3       |
|                               | Protestant| 43    | 65.2       |
|                               | Muslim    | 3     | 4.5        |
| Level of Education            | Diploma   | 43    | 65.2       |
|                               | Degree    | 23    | 34.8       |
| Profession                    | Midwifery | 8     | 12.1       |
|                               | Nurse     | 57    | 86.4       |
|                               | Other     | 1     | 1.5        |
| Work experience               | ≤ 2 years | 10    | 15.2       |
|                               | > 2 years | 56    | 84.8       |
| Ever trained on Respectful care | No    | 28    | 42.4       |
|                               | Yes      | 38    | 57.6       |
| Satisfied                     | No       | 17    | 25.8       |
|                               | Yes      | 49    | 74.2       |
Table 4: Ordinal regression table indicating factors associated with Respectful family planning Service in Sidama zone, Ethiopia, 2018

| Variables                      | Low vs moderate and high | Moderate and low vs high |
|--------------------------------|--------------------------|--------------------------|
|                                | Odds Ratio | P>|z| | [95% Conf. Interval] | Odds Ratio | P>|z| |
| RESIDENC (=urban)              | .774       | 0.110  | .565  | 1.060  | .774  | 0.110  |
| Short acting method*           | .296       | 0.007  | .122  | .722   | 2.106 | 0.000  |
| Uneducated**                   | .389       | 0.000  | .250  | .606   | .389  | 0.000  |
| Elementary school*             | .405       | 0.003  | .225  | .729   | .711  | 0.078  |
| Under Poverty**                | .745       | 0.040  | .563  | .986   | .745  | 0.040  |
| Gravida3plus                   | 1.193      | 0.338  | .831  | 1.714  | 1.193 | 0.338  |
| Age ≤24                        | 1.246      | 0.343  | .791  | 1.964  | 1.246 | 0.343  |
| Age 25 - 29                    | 1.027      | 0.888  | .712  | 1.481  | 1.027 | 0.888  |
| Wait time >30minute            | 1.485      | 0.315  | .687  | 3.207  | .458  | 0.000  |
| Duration of procedure >10 minute| .700      | 0.078  | .470  | 1.041  | .700  | 0.078  |
| Sex of service Provider(=male) | .782       | 0.140  | .563  | 1.084  | .782  | 0.140  |
| Trained on RMC*                | 8.750      | 0.000  | 4.608 | 16.615 | 3.032 | 0.000  |
| Satisfied Providers**          | 1.553      | 0.007  | 1.127 | 2.138  | 1.553 | 0.007  |
| Preferred opposite sex*        | 1.997      | 0.033  | 1.057 | 3.775  | .552  | 0.000  |
| _cons | 25.911 | 0.000 | 8.746 | 76.766 | 25.911 | 0.000  |

**Proportional odds assumption fulfilled.  *Proportional odds assumption not fulfilled**
Figure 1

Pie Chart showing level of Respectful family planning Service in Sidama zone, Ethiopia, 2018