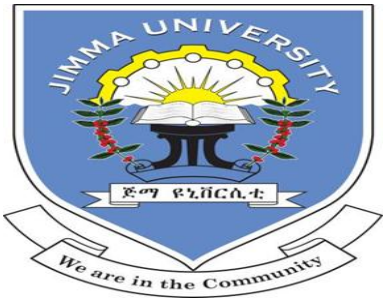

Jimma University

College of Education and Behavioral sciences

Departments of psychology

Family Planning Counseling Services for Pregnant Women Attending Prenatal Care and Its Challenges in Jimma Town Health Centers

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A Research paper submitted to Jimma University, College of Education and Behavioral Sciences, Department of Psychology in partial fulfillment of the requirements of Masters of Arts Degree in Counseling Psychology

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Examiners Board sheet

JIMMA UNIVERSITY

COLLEGE OF EDUCATION AND BEHAVIORAL SCIENCES,

DEPARTMENT OF PSYCHOLOGY (COUNSELING PSYCHOLOGY SPECIALIZATION)

Family Planning Counseling Services for Pregnant Women Attending Prenatal Care and Its Challenges in Jimma Town Health Centers

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Declaration

I declare this paper entitled Family Planning Counseling Services for Pregnant Women Attending Prenatal Care and Its Challenges in Jimma Town Health Centers Submitted to college of education and behavioral sciences department of Psychology in partial fulfillment for the requirements of Master of Arts degree in counseling psychology by Esrael Tilahun

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Abbreviations

ANC - Antenatal care

CSE - Contraceptive self-efficacy

FGAE - Family guidance association of Ethiopia

FP - Family planning

IEC- Information Education and Communication

LARCs - long-acting reversible contraceptives

MCH - Mother & child health

MOH - Ministry of health

PNC - Postnatal care

Abstract

The purpose of this research was to investigate quality of family planning counseling and related factors during prenatal care in Jimma town health centers. This study was a mixed Research design which composed of quantitative and qualitative approaches. The sample of the study consists of 240 women for quantitative survey. On the other hand, 12 women and 8 midwiferies were included in the qualitative part. To collect the quantitative data, survey questionnaire on socio-demographic, reproductive, self-efficacy and quality of counseling was administered for study participants via face to face interview. In-depth interview questions were used collect quantitative data from selected women and providers. The data were edited, and entered into and analyzed by SPSS version 25.0 for analysis. Descriptive statistics such as proportion, mean and standard deviation were computed based on the nature of variables. Bivariate analysis i.e. correlation was conducted. Multivariable logistic regression was done to identify factors associated with quality of counseling provided. P-value of less than 0.05 was used to declare statistical significance. In this study, more than half of women were not receiving enough information during family planning counseling during prenatal period. The counseling was tilted to only one or two options, the long term reversible contraceptives (IUCD and implant). Workload, shortage of providers, women's misconception and competing priorities issues like complication during pregnancy were the challenges reported by providers. Compared to uneducated mother, the odds of receiving quality among educated mothers (at least grade9th) was 2.07 times higher [Adjusted OR = 2.07, 95% CI: 1.05 – 4.06]. Similarly, among mother with primary education status, the odds of reporting quality counseling were 1.80 times higher as compared to the uneducated mother, though it is not statistically significant at p-value less than 0.05. Women who used modern contraceptives before the pregnancy were 3 times higher [Adjusted OR =3.05, 95% CI 1.71 - 5.45] to receive quality counseling as compared to those who did not use modern contraceptive. Furthermore, the odds of reporting quality counseling received were 1.56 higher for antenatal care visit increase by one unity. In conclusion, the quality of family planning counseling is not satisfactory and tilted to few options which are against the standard. I recommend providers to take into account women's perception and the factors into consideration while providing prenatal care. Finally I recommend further study to be conducted by including all type of facility and obtaining data via direct observation of the counseling sessions.

Key words: Family Planning, parental counseling, Jimma

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Chapter one: Introduction

1.1 Background of the study

Family planning refers to an individual's or couple's ability to decide when to have children, how many children they want in a family, and how to space their children. It is a method of promoting women's and families' health (Cleland, 2006). Family planning (FP) is part of a comprehensive strategy to reduce maternal, infant, and child mortality and morbidity. It is also an important part of reproductive health programs. Improving family planning services in high-fertility countries has the potential to reduce poverty (Cleland, 2006 FMOH, 2011).

Family planning is a core component of the Sustainable Development Goal 3.7 (universal access to sexual and reproductive healthcare services, including family planning). Fundamentally, access to Family planning information and services is a human right that advances other human right aspects. Quality Family planning information and services reinforce people's freedom to determine the number and spacing of their children and offer a range of potential benefits encompassing women's empowerment, economic development, education and improved health outcomes, including maternal and child health. However, in low- and middle-income countries, around 218 million women of reproductive age still have an unmet need for contraception in 2019 – meeting this need could drop annually an estimated 111 to 35 million unintended pregnancies, 35 to 10 million unsafe abortions, and 299 000 maternal deaths to 113 000 (Ali and tran, 2021, Guttmacher Institute, 2020, Katherine, 2016.)

Many contraceptive users discontinue their methods or fail to use them optimally. Quality contraceptive counseling has the potential to play a key role in supporting individuals select a method that matches their needs and expectations, mitigate any side effects, continue their method, or turn to other options, thereby reducing the unmet need for contraception, among other factors (Dehlendorf et al., 2014). In the Ethiopian Context Family planning has been practiced in Ethiopia since 1966, thanks to concerned volunteers who founded the Ethiopian Family Guidance Association (FGAE). The Ministry of Health (MOH) has combined family planning with the mother & child health (MCH) services during early 1980. Despite a long history and

considerable effort, the population grew from 42.6 million in 1984 to more than 100 million in 2020 (Cleland, 2006; FMOH, 2011).

According to EDHS (2016), only a quarter of currently married women in Ethiopia aged 15–49 years use modern contraception, with injectable contraception accounting for 63.5 percent of all users. The use of modern reversible contraceptives, both short and long acting, remains low. Contraceptive discontinuation rates are also high for the majority of the country's available methods; women who use modern non - permanent contraceptives report discontinuation for reasons other than pregnancy/fertility. Improving the use of modern contraception has the potential to reduce unintended pregnancy and short inter-pregnancy intervals, which can lead to a decrease in adverse pregnancy outcomes (EDHS, 2016; FP2020s, 2020).

Family planning counseling is the process of providing information, dispelling myths, and assisting women in making an informed voluntary decision. The World Health Organization (WHO) has developed and recommended a variety of Information Education and Communication (IEC) tools to supplement family planning counseling. In low-income countries, using family planning would reduce unplanned pregnancies by more than two-thirds, prevent nearly 70% of maternal deaths, and reduce unsafe abortions by 73%. Counseling is an important component of family planning programs (Susheela et al., 2009; FMOH, 2011; WHO, 2001).

There is, however, no standard definition of contraceptive counseling, although the centrality of quality counseling is underscored in different frameworks and programmatic and policy recommendations ((Population Council. 2005., Holt. Et al, 2017). Relevant documents include the Bruce framework, which was published in 1990 and identified six dimensions of quality for family planning services: technical competence, follow-up and continuity mechanisms, and the appropriate constellation of services, in addition to three dimensions that are specifically related to counseling – choice of methods, the information given to clients, and interpersonal relations. Other quality components of contraceptive counseling – given in a client-centered approach – were outlined in recent years, including needs assessment, trust-building with clients, tailored communication, shared decision making (by eliciting and responding to client preferences), method choice, and follow-up. In 2018, Global *Handbook for Family Planning Providers* made further recommendations on interpersonal qualities, including respect and confidentiality (Ali and Tran, 2021). Counseling can either occur face-to face, using digital technology, or

combination thereof. For example, the definition of the Population Council includes only face-to-face interactions involving a two way communication between a counselor and an individual or couple, or a counselor and a group. The counselor gives evidence-based information and assists the individual, couple or group to make a decision about behavior change, taking into account the feelings and concerns.

According to CDC (2014), providing high-quality counseling services, establishing and maintaining rapport, assessing the client's needs and personalizing discussions accordingly is mandatory are important. In addition, working collaboratively with the client to develop a plan and provide information that the client can understand and retain increases client satisfaction. Excellent family planning counseling increases acceptance of family planning services and promotes effective use of family planning services. Furthermore counseling increases client satisfaction with family planning methods and services, improves continuation of family planning services, dispels rumors and corrects misunderstandings about contraceptive methods (Ali and Tran, 2021).

According to a Tanzanian study, 40 percent of women who visited a health facility for any health-related reason in the previous two years received FP counseling. FP counseling was missed at Antenatal care (ANC) and Postnatal care (PNC) visits by 31% and 26% of women who had given birth in the previous 30 months, respectively (Amour et al., 2021). Only 34.8 percent of the 400 women planning pregnancies in Addis Abeba were counseled about family planning (Teshome et al., 2017). Similarly, a study conducted in Ethiopia on the quality of family planning counseling among non-pregnant women found that it was of poor quality. The overall quality of family planning counseling was low, with only 30% of women reporting receiving adequate information during counseling (Hrusa et al., 2020).

Missed opportunity to prevent unintended pregnancies suggests that FP counseling should be better integrated into the ANC and PNC visits. The role of FP counseling during pregnancy is to assist in the selection of the most appropriate method of family planning and to resolve any issues that may arise with the method chosen. If a woman, preferably with her partner, can make an informed decision, she is more likely to be satisfied with the method chosen and continue to use it. Prenatal care is an excellent time to counsel women on family planning options (FMOH,

2011; FMOH, 2010; Barber et al., 2007). In fact, the antenatal period is an excellent time for FP counseling, as women begin to consider their future contraceptive options before giving birth.

Despite the benefits of family planning counseling and its integration with prenatal care mentioned above, little research has been conducted to assess the status of family planning counseling and its challenges in Ethiopia. Furthermore, no studies have been conducted to date to assess the quality of family planning counseling among women attending prenatal care in Jimma zone.

1.2 Statement of the problem

Counseling dimension in family planning is a health quality dimension that endeavors to deliver family planning services taking into account the predilections and ambitions of clients and the philosophies of their societies through organized counseling. This includes client satisfaction, client preference, and selection. Family planning counseling is the procedure of helping a client seeking contraceptive services from a trained health worker with an intention of making a well-versed and intended selection about the number of offspring and the spacing of the children that the family intends to raise by use of the most suitable family planning method. Health care workers play a significant part in counseling of clients for uptake of contraceptive services. Many health care providers have taken up counseling as part of their roles. Owing to its significance and practicality, counseling is expansively developing a foundation for operative execution for health programs related to sexual and reproductive health. The significance of counseling is well recognized for its contribution in the change of behavior positively especially geared in the direction of seeking health care, and also contraceptives. Family planning services are very critical services in preventive health especially at primary health care level (Saka et al., 2012).

In order to alleviate various health risks it is recommended to have at least 2 years between pregnancies, necessitating the use of an effective postpartum contraceptive method. Counseling for postpartum contraception can be given after birth, during prenatal care visits or both. Postpartum contraceptive counseling has been studied by several groups, but the prenatal period is usually neglected. Contraceptive counseling, given according to the needs of couples during routine prenatal care visits, especially in the third trimester, might increase the use of postpartum

contraception (Tüzün, et al 2010). Given its relevance, providing contraceptive counseling is nowadays considered standard component of perinatal care (Lopez, et al, 2012). Therefore, providing high quality and respectful contraceptive counseling is important to support modern contraceptive use and meet couples' family planning needs and goals (Ali et al., 2012; Jain et al., 2018; Hardee et al., 2014; Holt et al., 2017).

Besides, prior studies on specific contraceptive methods show that characteristics of FP counseling that are associated with the use and continuation of contraceptive methods include proper counseling on side effects and information, clarification of misconceptions, and addressing spousal dynamics like covert use and communication. Studies also suggest the importance of counseling that provide opportunities for information exchange to support a choice that fits the reproductive needs and goals of the patient (Chaovisitsaree et al., 2005; Ullah et al., 2006; Bryant et al., 2015; Tolley et al., 2005).

Despite the early and ongoing global work on the quality of FP counseling services, few studies in low and middle-income countries such as Ethiopia have tried to empirically assess FP counseling services (Jain et al., 2019). In Ethiopia, only one study was conducted on prenatal women in referral hospital (Teshome et al., 2017). Moreover, Factors affect quality of counseling is countless yet the role of women's socio-demographic and reproductive factors, previous experience of contraceptive use and challenges faced by providers are directly influential. However, the quality as well as factors associated with family planning counseling in Jimma health centers is not studied so far. A qualitative study focusing on the situation in which a provider provides counseling services to clients can shed light on counseling and provide a deeper understanding of a woman's experience during family planning counseling. Such information cannot be collected solely by standard structured surveys or surveys. Therefore, this article aims to evaluate family planning counseling during antenatal care with a mixed approach.

1.3 Research questions

The Study employed to answer the following four basic research questions:

1. How women perceive family planning counseling during prenatal care in Jimma town health centers?
2. What are the major challenges of family planning counseling service in Jimma Town health centers?
3. To what extent women receive quality family planning counseling services during prenatal care in Jimma town health centers?
4. What socio-demographic and reproductive factors are associated with family planning counseling during prenatal in Jimma town health centers?

1.4 Objectives

1.4.1 **General Objectives**

The main intent of this study was to assess family planning counseling and related factors during prenatal care in Jimma

1.4.2. Specific Objectives

1. To explore women's perception of family planning counseling during prenatal visit in Jimma City health Centers.
2. To identify the major challenges of family planning counseling service in Jimma Town health centers?
3. To assess women's perception of quality family planning counseling services during prenatal care in Jimma town health centers.
4. To assess socio-demographic and reproductive factors associated with family planning counseling services among women attending prenatal care clinic in Jimma town health centers.

1.5. Significant of the study

The aim of study was depicted a shed light on the family planning counseling received during attending prenatal care in Jimma town. In addition, the study was expected to pinpoint women's

perception of prenatal counseling and the main challenges phased by the health working in providing the counseling.

On the basis of this expectation, the results of this study are helpful for health care providers and stakeholders to increase quality of family planning counseling during prenatal care and eventually increase postpartum family planning uptake. The results of this study are an input for health centers and stakeholders working on family planning as it contribute to the existing part of knowledge regarding family planning counseling integration status at primary health care system in the country. Moreover, the results of this study also offer input for a non-governmental organization working in family planning area and for the researcher to conduct researches.

1.6. Scope of the study

Family planning counseling is provided by Public hospitals, Private Hospitals, Health centers, Private maternity clinics and NGO in Jimma Town. The study was limited to the health centers. The scope of the study was delimited the health centers to make it manageable for the study. In addition, the type of facility itself may matter regarding the quality of services partily by the quality and providers educational status, by the environment of the faculties. Moreover, there is a difference among women attend different hospital and health centers, private and public health facility. Thus, delimitation is by considering the manageability of the variables those are assumed to be factors for the reliability of the study.

1.7. Limitation of the study

Quality was assessing by self-report and it would have been done via observation of counseling section. Wealth index was not assessed instead month income was measure.

1.7. Operation definition

Family planning counseling- the provision of information and assistance in choosing a method that meets a woman's needs and preferences has radical potential to increase use of modern methods and reduce discontinuation rates

Prenatal care- is the health care a woman gets while she is pregnant.

Quality of FP Counseling – counseling that can both enhance clients' experience of care and improve their ability to make and act on their contraceptive decisions.

Contraceptive self-efficacy (CSE) is a woman's belief in her own ability to succeed in contraceptive initiation, management and continued use after delivery.

Chapter two: Literature review

Introduction

In this chapter review, relevant literature in view of the research problem is presented. The chapter begins with the different definitions and basic concepts family planning counseling then the theoretical framework of the study is clearly elaborated. Next, the empirical review based on the contribution of quality counseling during prenatal care on postnatal family planning uptake is presented. The literature is organized in accordance to the study objectives. The chapter ends with the summary of reviewed literature and research gaps.

2.1 Definition and basic concepts of family planning counseling

Counseling is a type of client-provider interaction that involves two-way communication between a health care staff member and a client for the purpose of confirming or facilitating an informed decision by the client or helping the client address problems or concerns. Quality counseling is the main way that health workers support and safeguard the client's rights to informed and voluntary decision-making. This means never pressuring a client to choose one family planning method over another, or otherwise limiting a client's choices for any reason other than medical eligibility. Counseling can support all other clients' rights as well. Counseling for family planning helps clients choose and use family planning methods that suit clients' needs (Saka et al., 2012).

2.2 Theoretical frame work of the study

The centrality of quality counseling is underscored in different frameworks and programmatic and policy recommendations (Bruce, 1990, Donabedian's, 1966, Population Council. 2005., Holt. Et al, 2017). A focus on quality in family planning began most notably with Bruce's (1990) publication of a framework to assess quality from the client's perspective, informed by Donabedian's (1966) foundational definition of health care quality in terms of structure, process and outcome elements. Bruce's (1990) work came more than a decade before the United States Institute of Medicine's groundbreaking report crossing the Quality Chasm and the World Health Organization's publication of guidance for quality improvement in health systems (Institute of

medicine, 2001), and has informed countless efforts to monitor and improve family planning programs. Its focus on quality from the client's perspective is in line with the now prominent "Triple Aim" framework which includes patient experience as one of three organizing principles of optimal health systems, in addition to cost and population health (Berwick et al., 2008).

The Bruce framework identified six dimensions of quality for family planning services: technical competence, follow-up and continuity mechanisms, and the appropriate constellation of services, in addition to three dimensions that are specifically related to counseling – choice of methods, the information given to clients, and interpersonal relations. Other quality components of contraceptive counseling – given in a client-centered approach – were outlined in recent years, including needs assessment, trust-building with clients, tailored communication, shared decision making (by eliciting and responding to client preferences), method choice, and follow-up. In 2018, Global Handbook for Family Planning Providers made further recommendations on interpersonal qualities, including respect and confidentiality. Counseling can either occur face-to face, using digital technology, or combination thereof. For example, the definition of the Population Council includes only face-to-face interactions involving a two way communication between a counselor and an individual or couple, or a counselor and a group. The counselor gives evidence-based information and assists the individual, couple or group to make a decision about behavior change, taking into account the feelings and concerns.

2.3 Empirical review Family planning counseling

Despite this early work on quality in family planning, interest in individuals' perspectives has continued to take a backseat to a focus on promoting access to and uptake of contraception. This is illustrated by the predominant focus on population-based numeric measures and targets, with less attention paid to understanding and optimizing individuals' experiences with services. The emphasis on access and numeric targets is exemplified by the Family Planning 2020 Initiative's central goal of enabling 120 million more women and girls to use contraceptives by the year 2020. Further, the use of long-acting reversible contraceptives (LARCs), which are highly effective pregnancy prevention methods, is increasingly being promoted. These LARC-focused efforts include, in some cases, tracking the proportion of individuals in a health system using these methods as a means to incentivize their provision (Belden, 2014).

Use of numeric targets and incentives persists despite the pivotal 1994 International Conference on Population and Development (ICPD) calling for prioritization of individuals' needs and perspectives related to family planning, and discontinuation of incentives and quota at the programmatic level due to the potential that these strategies are counterproductive or coercive (United Nations Population, 1994). While a continued emphasis on monitoring and promoting uptake of contraception and LARC is motivated by well-intentioned desires to ensure that individuals have tools needed to prevent unintended pregnancies, experts have raised concern over the potential negative—if unintentional —impacts on quality of care, particularly related to respect for autonomy and decision-making, if health care providers are incentivized to push for use of methods rather than enable individuals to make the best decisions for themselves (RamaRao and Jain, 2015; Jain et al, 2012).

In this context, a renewed focus on understanding individuals' experiences with contraceptive services —in particular, counseling around method choice and use—is critical to ensuring that individuals' needs are respected and Additionally, because counseling has been associated with contraceptive use and continuation in a number of settings (Jain et al, 2012; Lei et al., 1996) ensuring that individuals have positive counseling experiences can actually contribute to efforts to meet demand for contraception and reduce unintended pregnancy at a population level. Further, quality counseling has the potential to boost individuals' likelihood of returning to the health system if they are not satisfied(WHO, 2014), addressing what Jain et al(2012) has termed the "leaking bucket" problem whereby individuals unsatisfied with their method choice discontinue use despite still desiring fertility control.

In order for the field of family planning to effectively refocus on individuals' experiences with counseling, a comprehensive definition of what high-quality contraceptive counseling should entail is necessary. Given the centrality of reproduction to the human experience, the provision of contraceptive care must be informed by several principles of universal human rights. The right to the highest attainable standard of health, rights to education and information, and the right to nondiscrimination, established in international human rights treaties, has implications for the provision of sexual and reproductive health services, including contraceptive care, and governments' duties to respect, protect and fulfill these rights. The resurgence of attention to the implications of human rights principles for contraceptive service provision following the

landmark 2012 London Summit on Family Planning merits a refocusing of our conceptualization of good communication between providers and individuals in terms of human rights (WHO, 2014).

2.3.1 Women's perception of family planning counseling

According to xx, women perceived that it was important to feel comfortable during visits, to feel that their decision-making autonomy was respected, to have providers show empathy and be nonjudgmental, and to see the same provider across visits.

The need for improved privacy, a wider choice of contraceptive methods and accurate and more comprehensive information about methods and side effects were stress. The Respondents reported the friendliness of the service providers that made them feel confident with the contraceptive counseling. Women responded that the main reason for choosing the intrauterine device was the advice given by the physician or other health professional (87%). In 8.3% of cases, it was due to personal research and in 4.6% to family or friends' advice. Women's main concern regarding this method was the placement process (26.9%). Others reported fear of complications (23.1%), becoming pregnant (18.5%), gaining weight (9.3%) or not adapting to the method (15.7%). 15% of women did not have any concerns (Gaspar1 et al, 2022).

2.3.2 Magnitude of family planning counseling during prenatal care

According to a Tanzanian study, 40 percent of women who visited a health facility for any health-related reason in the previous two years received FP counseling. FP counseling was missed at Antenatal care (ANC) and Postnatal care (PNC) visits by 31% and 26% of women who had given birth in the previous 30 months, respectively (Amour et al., 2021). Only 34.8 percent of the 400 women planning pregnancies in Addis Abeba were counseled about family planning (Teshome et al., 2017). Similarly, a study conducted in Ethiopia on the quality of family planning counseling among non-pregnant women found that it was of poor quality. The overall quality of family planning counseling was low, with only 30% of women reporting receiving adequate information during counseling (Hrusa et al., 2020).

2.3.3 Factors affecting family planning counseling

The perceived barriers to the use of family planning included lack of knowledge about family planning use, fear of side effects of modern family planning methods, lack of access/affordability due to familial and religious beliefs/myths/ misconceptions. On an individual level, some couples' timid nature also negatively influenced the uptake of family planning measures (Bhatt et al. 2021).

Efforts in this area are especially important considering challenges that may hinder the delivery of client-centered care, such as time constraints and competing medical priorities during visits. Health professionals tend to underestimate the interest of women in receiving information about contraception in general, and more specifically about LARCs.

Shorter client waiting time, presence of competent healthcare providers, provision/prescription of injectable methods, maintenance of privacy, and confidentiality were the most commonly identified factors positively associated with quality of care in FP services, provider workload. These studies that identified factors associated with quality of care in FP services were pointed to quality of care was associated with client's age, educational status, providers' experiences, client's waiting time, clients' perception on adequacy of information during consultation, ease of getting the health facility.

Workers listed their main problems as inadequate staffing, limited attendance time, client overload, the community's negative attitude towards state-run health facilities, and common misperceptions regarding various contraceptive modalities (Majlessi1, F., Banaem, LM., Shariat, M. 2021).

The likelihood of good quality counseling was the least among those who had no formal schooling when compared to those who had higher educational attainment. Women from the wealthiest quintile were more likely to receive good quality counseling when compared to women in the lower wealth quintile. Age and marital status are also associated factors (Hrusa, 2020).

Women who were not formally employed were more likely to receive FP counseling during facility visit than others. Women in reproductive age who received any FP counseling at PNC

were significantly more likely to report current use of modern contraception than those who did not (Amour, 2021),

2.4 The gaps of the study and Recommendations

There is little research conducted on the topic area as a national level in general and in the study area in particular. The first study was only conducted in Addis Abba in Hospital setting. The second study was on conducted among women in reproductive age. The recommendations given for future studies were stated as more studies to be conducted including in all tier of Health system using both research approaches.

Chapter three: Research methods

3.1 Study area and period

The study was conducted in Jimma town. Jimma town is located at 351 km from Addis Ababa in southwest direction. The town is the largest town in southwestern Oromia Region, Ethiopia. It is a special zone of the Oromia Region and is surrounded by Jimma Zone. It has a latitude and longitude of 7°40′N 36°50′E. prior to the 2007 census, Jimma was reorganized administratively as a special Zone with the total population 120,960 according to 2007 census. The town has one specialized hospital (Jimma Medical center of Jimma University), one zonal hospital (shanen Gibe hospital), four health centers, private primary hospitals, medium clinics and NGO centers. This study was conducted in the four health centers in Jimma town. The centers have MCH departments that provide prenatal care, delivery care and postnatal care. Family planning services are integrated with antenatal, delivery and postnatal services in these health centers. The study was conducted from April 15 to May 15/ 2022.

3.2 Study design

In this study, a mixed approach of quantitative and qualitative research strategies was conducted. The basic premise of mixed research methodologies is that the combination of quantitative and qualitative methods providing a comprehensive understanding of the research problem compared to applying only one type of method (Molina-Azorin, 2016; Mitchell, 2018). Mixed study provides both quantitative and qualitative recognition, leading to good data elucidation and a good understanding of the subject of the study. Mixed approaches provided additional considerations for multifaceted phenomena that may not be available using a single method. Mixed method is a survey management method that includes the collection, review and adjustment of quantifiable statistics such as surveys and qualitative interviews (Creswell, J.W. & Plano-Clark, V.L., 2018). The choice of mixing method is intended to provide a better explanation of the research problem. This method was chosen based on the background that there are no mixed studies to measure the quality of counseling, especially regarding family planning during pregnancy. Therefore, it was of utmost importance for researcher to continuously investigate research questions from different angles and use methods that could unravel possible unexpected discoveries and inconsistencies. The advantage of using the mixed approach was that

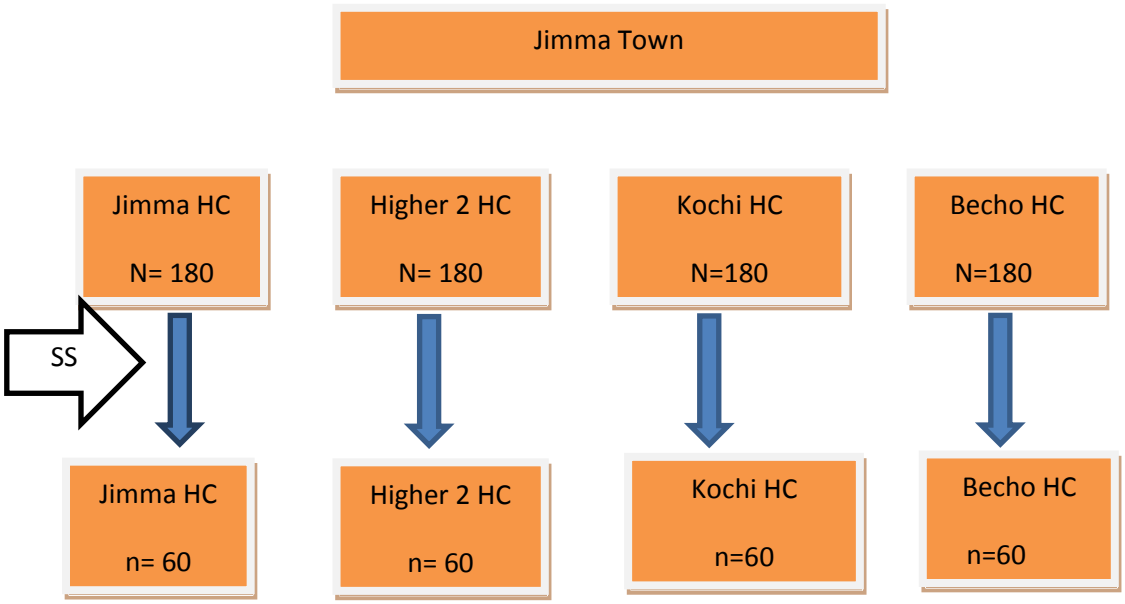
the investigator could examine the consistency of the results obtained through the final interview and the detailed interviews with women and healthcare providers. This study employs a descriptive and analytical study using a mixed-method study design.

3.3 Population of the Study

All pregnant women who attended the clinic for at least the second prenatal visit during the study period and provider or health professionals working the centers were the source population for this study. While Study population is selected pregnant women attended the clinic for at least the second prenatal visit during the study period was the study population. In addition, providers working in the prenatal and on duty on a date of data collection were included.

3.4 Sample size and sampling technique

The sample size was calculated by using single proportion formula. Proportion of family planning counseling was estimated from a previous research conducted as 35% (Teshome *et al*, 2017). At 5% level of significance 5% margin of error and 5% non-response rate, and correction for finite population, the final sample size was 248. Systematic sampling was utilized to recruit participants from ANC followers at prenatal clinics. On average the health centers provide care for 180 pregnant women monthly, making 720 pregnant women for the four health centers, sample interval is 3 and after a random start from the three first comer every morning, the mothers were recruited every 3rd. The total sample size was equally divided for the four health centers, all health centers were included. For qualitative interview a total of 12 mothers were interviewed and 8 providers (2 health workers from each health center) on duty on the day of interview) were included.



Key: SS= systematic sampling HC = Health Center

Figure 1 Schematic presentation of sampling

3.5 Instrument for data collection

In the current study, structured questionnaire and in-depth interview guide were used. The Questionnaire was developed in a way that it would maximize the possibility of generating answers to the basic research questions. They were direct to the respondent via face-to face interview conduct at the health centers. The questionnaire was developed in English, then translated into local languages (Afaan oromo and Amharic) and back- translation into English to check consistency. The questionnaire has three parts for socio-demographic and reproductive health, self-efficacy and quality of counseling. The questionnaire was adapted by reviewing literature. Quality of family planning counseling was measured by 13 items (yes no) adapted from literature. As our primary interest was specific to the patient provider interaction during counseling, we used the following three elements of the Bruce (1990) framework a) FP counselors' provision of information b) eliciting client's FP history and preferences, and c)the respectful and engaging interaction between the counselor or and the client. Contraceptive self-efficacy (CSE) is a woman's belief in her own ability to succeed in contraceptive initiation,

management and continued use after delivery. In this study it was measured by 8 items (yes no). The qualitative part will be collected by using interview guide designed for this purpose.

3.6 Methods of data collection and measurement

Quantitative data was collected by means of an exit interview conducted at the prenatal clinic by experienced data collectors. The data was collected by four experienced data collectors and in-depth interview with both mothers and providers was collected by one experienced data collectors. Quality of FP counseling, which is assessed by measure any experience with FP counseling during the ANC visits. The variable was categorized as: Receipt of lower quality counseling and Receipt of higher quality counseling.

3.7 Variables

Dependent variable

Quality of family planning counseling

Independent variable

Socio-demographic variables:

Age of woman,

Religion,

Women's educational status,

Income

Marital status and

Occupation

Reproductive variables:

Number of living children,

Wanted pregnancy,

Previous history of contraceptive use and

Intention to use contraception after delivery and

Contraceptive us self-efficacy

3.8 Data processing and analysis

Quantitative data was cleaned, coded, entered in to and analyzed by using SPSS version 24. Data analysis was started by describing each variables involved. Bivariate analysis was done.

For the third specific objectives, variables with p-value less than 0.25 in the bivariate analysis were considered as candidate to be entered in multiple logistic regression models. The using backward elimination method the final model was fitted. Statistically significant association was declared at p-value less than 0.05. Adjusted Odds ratio and 95% CI interval will be reported. The model fitness was checked using Cox and Snell R square. The result was be presented by using tables and figures. For qualitative data, thematic analysis was used.

3.9 Quality control

The quality of the data was assured by using a pre-tested questionnaire on 5% of the study women in Shenen Gibe Hospital. Data was collected by experience data collectors and a half day briefing on the tool was given for data collectors.

3.10 Ethical consideration

Letter of ethical approval was obtained from Jimma University, college of education and behavioral sciences review board. Letter of cooperation write by the department was given to each Health center for permission. Before data collection every mother was asked to give verbal consent after explaining the purpose, how they were selected, nature of the study and their full right to decline from participation in the study or withdraw at any time in the process. Respondents were assured for confidentiality of the data.

Chapter Four: Results

The aim of the study was to investigate family planning counseling and related factors during prenatal care in Jimma. In the present chapter, the data generated from the current study participants were presented in line with of the research question.

4.1 Socio-demographic characteristics of study participants

From the total of 248 planned study participants, 240 (96.77%) took apart in the quantitative survey. All of the respondents were married. From the total study participants, 143(59.6%) of respondents were in the age group of 25 to 34 years. Majority of the mothers (58.3%) had one to three children. One hundred eight (455 %) respondents were housewives. Seventy eight (32.5 %) respondents did not receive formal education while 104(43.3%) of the respondent completed at least 9th grade (table 1). For the qualitative study, as planned 12 pregnant women and eight health care professionals were included (table 2).

Table 1: Socio-demographic characteristics of respondents in Jimma Town (n= 240)

Variables	Frequency	Percentage
Age of the mothers(in Years)		
Less than 24	72	30.0
From 25 to 34	143	59.6
Greater than 34	25	10.4
Occupation of the mothers		
Housewife	108	45.0
Merchant	57	23.8
Employed	50	20.8
Day labor	16	6.7
Others(student, farmer)	9	3.8
Religion of the mothers		
Muslim	106	44.2
Orthodox	84	35.0
Protestant	50	20.8
Number of children		
Primi mother	69	28.8
1-3 children	140	58.3
Greater than four children	17	12.5
Educational status		
Illiterate	78	32.5
Primary	58	24.2
Secondary and above	104	43.3

Table 2: Characteristics of interviewed women (n=12) and health professional (n=8)

Women	**Number**
Age	
Less than 24	2
25 to 35	6
Greater than 35	4
ANC	
3rd	6
4th	6
Level of education	
Primary	5
Secondary	7
Health professionals	
Years of experiences	
Less than 2	2
2-5	4
Greater than 5	2

4.2 Women's perception of family Planning counseling

The counseling received during ANC visits was limited to a single or few methods, typically loop or the one put in the uterus. Information about other methods was often given during counseling up on request from clients. The majority of women had loop or the one inserted in uterus mentioned to them during ANC visits, but only about few stated that they were counseled on the method. Some women were told that they could receive IUD after delivery but were not given information that differentiated the option from postpartum methods. Family planning counseling during ANC help women to plan ahead to avoid unwanted pregnancy if done correctly.

For example:

"They just provided information about IUCD and tried to convince me to agree to be inserted after delivery. But I have to discuss about this method with my husband before I agree".

- 25 years old, 10 years of education

"*They didn't explain me everything about the method (IUCD). They just told me that if I give birth to my child in that hospital and if I agree in using it, they will insert it after I deliver my*

baby. They also stated that I can use it as long as I want to and can remove it if I do not have the desire to continue the method".

– 20 years old, 10+3 years of education

In addition to counseling being limited to certain methods, women's choice was limited due to their lack of decision-making power.. Respect and friendly approaches were important during counseling.

4.3 Major Challenges of family planning counseling service

The main challenges were originated from the facility and the clients. Facility related challenges were high workload and limited number of providers and space(one room and one bed). Client related factors are attitude and ill preference of women toward some family planning method. Providers were providing counseling for ANC follower. There were circumstances that hinder them from proving quality counseling or family planning counseling at all during ANC such as workload and work overlap as we work both at prenatal care and delivery care. Family planning counseling is usually provided at late ANC visit during third and fourth with birth preparedness. There may be computing priority issues like complications. Clients usually come on Monday and Thursday(immunization day) the ANC service is provider from Monday to Friday. This pattern client flow hinders quality counseling as there is short stay between provider and clients.

For example

"I counsel client about nutrition, personal hygiene, danger sign and family planning. Some of our clients select IUCD to be inserted just after delivery before discharge"

-Diploma midwifery working in the center for more than 5 years.

Majority of women want to hear about injectable contraceptive only. Women were counsel about long term contraceptives specially IUCD. As it is possible to insert right after delivery before they get discharged from delivery center. It completely project women from risk of pregnancy that may occurs after a couples of weeks after delivery. It is also safe as it is non-hormonal contraceptive. However, they are not happy to discuss about the loop. They think their husband may not be willing.

"*We need to work hard on to move our client preference from injectable to the long-term contraceptive methods. I do not know why they insist on the injectable one. Even, they are not willing to try the other options except injectable".*

4.4 Quality of FP counseling and Factors associated with quality of family planning counseling

Over all, from the total participants, 43.33% [95% 37.06% - 49.60%] of participants reported being received quality family planning counseling.

Table 3: quality of Family planning counseling during prenatal care in Jimma Health centers (n= 240), Ethiopia, 2022

Items	Yes
Did the provider ask you about your reproductive goal, i.e. how many children do you have, and how many you want?	90(37.5)
Did the provider ask you about different methods you have used earlier?	83 (34.6)
Did the provider ask you about problems you have had with earlier methods?	65(27.1)
Did the provider ask your method preference?	79(32.9)
Did the provider tell you about different FP methods?	54(22.5)
Did the provider explain you how to use the method you selected?	42(17.5)
Did the provider tell you about possible side effects of the method you selected?	31(12.9)
Did the provider tell you what to do if you experience any problem after using the method you selected?	81(33.8)
Did the provider encourage you to ask questions?	46(19.2)
Was the time spent in consultation sufficient to discuss your needs?	44(18.3)
Did the provider treat you in a friendly way?	96(40)
Did provider treat you in a respectful way?	96(40)
Any time during the discussion with the health provider, did you feel that he/she is pressurizing you to select a particular family planning method?	194(80.8

In bivariate analysis age of the mothers, educational status of the mothers, number of ANC visit, planned pregnancy and intention to use contraceptive after delivery were selected as candidate variable for multivariable logistic regression at P-value less than 0.25.

Results of the bivariate analysis showed that the correlates of education, birth history, residence, previous contraception use were all significant predictors of quality of counseling. When compared to women with no formal education, those who learned secondary school and above

were more likely to receive good quality counseling (crude OR: 2.34, 95% CI: 1.26, 4.32, p = 0.01) while previous contraceptive users were 2.21 times more likely (95% CI: 1.31, 3.73, p = 0.003) to receive good quality. Furthermore, in the bivariate analysis, number of birth, age, religion and occupation were not significant predictors (table 4). Income, residence and marital status were not included in the analysis of factors because residence and marital status did not vary across the participants and income was with missing values.

Table 4: Characteristics of respondents by quality of counseling and logistic regression results in Jimma town, (n = 240), Ethiopia, 2022

Variable	Quality of FP counseling		Crude OR(95%CI)	P-value
	Yes	No		
Age of the mothers(in Years)				
Less than 24	31	41	ref	
From 25 to 34	61	82	0.98(0.55, 1.74)	0.97
Greater than 34	12	13	1.22(0.49, 3.04)	0.67
Occupation of the mothers				
Housewife	41	67	ref	
Merchant	34	23	2.42(1.25, 4.67)	0.01
Employed	19	31	1.00(0.50, 1.99)	0.99
Day labor	5	11	0.74(0.24, 2.29)	0.61
Others(student, farmer)	5	4	2.04(1.25, 4.67)	0.31
Religion				
Muslim	44	62	ref	
Orthodox	39	45	1.22(0.69, 2.18)	0.49
Protestant	21	29	1.02(0.52, 2.02)	0.95
Intention of the pregnancy				
Not planned	7	18	ref	
Planned	97	118	2.11(0.85, 5.27)	0.11
Number of children	1.55± 1.39	1.45 ± 1.61	0.90(0.76, 1.08)	0.26
Number of Antenatal care visit	3.62 ± 0.80	3.34 ± 0.95	1.44(1.07, 1.93)	0.02
Intention to use FP after delivery				
No	49	87	ref	
Yes	55	49	1.99(1.18, 3.35)	0.01
Educational status				
Illiterate	24	54	ref	
Primary	27	31	1.96(0.97, 3.97)	0.06
Secondary and above	53	52	2.34(1.26, 4.32)	0.01
Previous History Family Planning Use				
Yes	48	89	ref	
No	56	47	2.21(1.31, 3.73)	0.003

In the multivariate analysis, age was no longer significant a predictor of quality counseling. On the contrary, education, previous use of modern contraceptive and number of antenatal care visit significant when adjusting for the other variables

The result of multivariable logistic regression analysis showed that were factors independently associated with quality of counseling. Compared to uneducated mother, the odds of receiving quality among educated mothers (at least grade9th) was 2.07 times higher [AOR = 2.07, 95% CI: 1.05 – 4.06]. Similarly, among mother with primary education status, the odds of reporting quality counseling were 1.80 times higher as compared to the uneducated mother, though it is not statistically significant at p-value less than 0.05. Women who used modern contraceptives before the pregnancy were 3 times higher [AOR =3.05, 95% CI 1.71 - 5.45] to receive quality counseling as compared to those who did not use modern contraceptive. Furthermore, the odds of reporting quality counseling received were 1.56 higher for antenatal care visit increase by one unity (table 5).

Table 5: Factors independently associated with quality of counseling in Jimma town, (n=240), Ethiopia, 2022

Variable	AOR(95%CI)	P-value
Educational status		
Illiterate	Ref	
Primary	1.80(0.86, 3.77)	0.12
Secondary and above	2.07(1.05, 4.06)	0.04
Previous History Family Planning Use		
Yes	Ref	
No	3.05(1.71, 5.45)	0.0001
Antenatal care visit	1.56(1.11, 2.19)	0.01

Chapter Five:

Discussion

Clients generally complained lack of counseling, if exist one or two options were topic of discussion. They complain that the method is imposed on them and that their views regarding the decision are not considered. Users demand more information about the different methods. In counseling, users demand more information about the different methods, in an environment of erroneous knowledge and misinformation, which lead to false beliefs and myths in the population that are not contrasted by the professional in counseling. They complain that the method is imposed on them and that their views regarding the decision are not considered (Laura et al 2021). Similarly, in a study conducted in Iran, the clients wanted to know about their right to make their own decisions based on accurate, comprehensive information, they also wanted to be respected in their contacts with health care providers. Most of them were unsatisfied with the center services (public sectors) (Majlessi1, F., Banaem, LM., Shariat, M. 2021)

The need for improved privacy, a wider choice of contraceptive methods and accurate and more comprehensive information about methods and side effects were stress. The Respondents reported the friendliness of the service providers that made them feel confident with the contraceptive counseling. Women responded that the main reason for choosing the intrauterine device was the advice given by the physician or other health professional (87%). In 8.3% of cases, it was due to personal research and in 4.6% to family or friends' advice. Women's main concern regarding this method was the placement process (26.9%). Others reported fear of complications (23.1%), becoming pregnant (18.5%), gaining weight (9.3%) or not adapting to the method (15.7%). 15% of women did not have any concerns (Gaspar1 et al, 2022).

Workers listed their main problems as inadequate staffing, limited attendance time, client overload, the community's negative attitude towards long term family planning, and common misperceptions regarding various contraceptive modalities. Similar result was reported from study done in Iran (Majlessi1, F., Banaem, LM., Shariat, M. 2021)

The level of quality counseling render for the mother at health center was 44.33%. This is in line with the study conducted in Tanzania among the women that visited the health facility for any health-related visit in the past two years 40% reported that they received FP counseling (Amour et al., 2021). This is higher than the study done in Ethiopia with quality of counseling on family planning with only 30% (Hrusa et al., 2020). The difference is due to the difference population, the women in reproductive age were the study population for the study done by Hrusa et al.

Factors that influenced the likelihood of women receiving better counseling were also identified. I found no evidence that age influences the likelihood of a woman receiving good quality counseling. This is contrary to the study that showed age is associated quality of counseling received. Ethiopian adolescents have been identified as being at a higher risk of receiving poorer quality family planning services, including counseling (Bitzer et al, 2016). Throughout Ethiopia, socially acceptable sexual activity, childbearing, and contraception use are restricted to the context of marriage, which was by the universal marital status among the study respondents and Hounton et al.(2015) also reported marriage is the most common marital status category. As a result, this could explain why marital status and birth history were not significant predictors of counseling quality in this study. Despite the fact that age was not a factor in the findings of this study, policies should be maintained.

When compared to those with higher educational attainment, those with no formal schooling had the lowest likelihood of receiving good quality counseling. In this study, educational status was found to be significantly associated with counseling quality, as education improves service quality. This finding is consistent with research conducted in Ethiopia (Hrusa et al., 2020). This is consistent with findings from other countries (Jain, 2016). In terms of education, Jain (2016) discovered that in the Sub-Saharan Africa region, counseling quality increased with client education. The discovery regarding women's educational status and its role in other positive family planning outcomes emphasizes the importance of promoting proper education among Ethiopian women.

Contraception history use was found to be significantly related to counseling quality. This is because experience helps the clients to question when they did not understand what they provider is advising from their experience.

Chapter Six:

Summary, Conclusion and Recommendation

6.1. Summary

The main challenges were originated from the facility and the clients. Facility related challenges were high workload and limited number of providers and space(one room and one bed). Client related factors are attitude and ill preference of women toward some family planning method. Providers were providing counseling for ANC follower. There were circumstances that hinder them from proving quality counseling or family planning counseling at all during ANC such as workload and work overlap as we work both at prenatal care and delivery care. Family planning counseling is usually provided at late ANC visit during third and fourth with birth preparedness. There may be computing priority issues like complications.

Majority of women want to hear about injectable contraceptive only. Women were counsel about long term contraceptives specially IUCD. As it is possible to insert right after delivery before they get discharged from delivery center. It completely project women from risk of pregnancy that may occurs after a couples of weeks after delivery. It is also safe as it is non-hormonal contraceptive. However, they are not happy to discuss about the loop. They think their husband may not be willing.

In bivariate analysis age of the mothers, educational status of the mothers, number of ANC visit, planned pregnancy and intention to use contraceptive after delivery were selected as candidate variable for multivariable logistic regression at P-value less than 0.25.

Results of the bivariate analysis showed that the correlates of education, birth history, residence, previous contraception use were all significant predictors of quality of counseling. When compared to women with no formal education, those who learned secondary school and above were more likely to receive good quality counseling (crude OR: 2.34, 95% CI: 1.26, 4.32, p = 0.01) while previous contraceptive users were 2.21 times more likely (95% CI: 1.31, 3.73, p = 0.003) to receive good quality.

The result of multivariable logistic regression analysis showed that were factors independently associated with quality of counseling. Compared to uneducated mother, the odds of receiving quality among educated mothers (at least grade9^{th}) was 2.07 times higher [AOR = 2.07, 95% CI:

1.05 – 4.06]. Similarly, among mother with primary education status, the odds of reporting quality counseling were 1.80 times higher as compared to the uneducated mother, though it is not statistically significant at p-value less than 0.05. Women who used modern contraceptives before the pregnancy were 3 times higher [AOR =3.05, 95% CI 1.71 - 5.45] to receive quality counseling as compared to those who did not use modern contraceptive

6.2. Conclusion

The majority of women had loop or the one inserted in uterus mentioned to them during ANC visits, but only about few stated that they were counseled on the method. Some women were told that they could receive IUD after delivery but were not given information that differentiated the option from postpartum methods. Family planning counseling during ANC help women to plan ahead to avoid unwanted pregnancy if done correctly.

Counseling focused on the woman herself, and in these cases, the woman did not have a full choice of methods despite their availability. Husbands have no good attitude about the loop which was usually promoted in the facility. Respect and friendly approaches were important during counseling.

As it is possible to insert right after delivery before they get discharged from delivery center. It completely project women from risk of pregnancy that may occurs after a couples of weeks after delivery. It is also safe as it is non-hormonal contraceptive. However, they are not happy to discuss about the loop. They think their husband may not be willing. Furthermore, in the bivariate analysis, number of birth, age, religion and occupation were not significant predictors (table 2). Income, residence and marital status were not included in the analysis of factors because residence and marital status did not vary across the participants and income was with missing values.

The results revealed key findings: First, Women were not receiving enough information during family planning counseling during prenatal period. Women perceive the counseling service is not adequate and focus on few options. Inadequate staffing, limited attendance time, client overload, the community's negative attitude towards long term family planning, and common misperceptions regarding various contraceptive modalities were the challenges in providing quality counseling. Second, as expected, higher education was associated with increased quality

of family planning counseling. Women who obtained used contraceptive before being pregnant received significantly better-quality counseling from providers. Lastly, ANC visits increased the likelihood of receiving better-quality counseling increased.

6.3. Recommendation

- The majority of women had loop or the one inserted in uterus mentioned to them during ANC visits, but only about few stated that they were counseled on the method. Some women were told that they could receive IUD after delivery but were not given information that differentiated the option from postpartum methods. So, concerned body should Providers should give focus and emphases on counsel family planning during ANC visit.
- Counseling focused on the woman herself, and in these cases, the woman did not have a full choice of methods despite their availability. Husbands have no good attitude about the loop which was usually promoted in the facility. Governments and no government organization should Providers should give counseling on the options of family planning and leave the choice for the mothers.
- Women were not receiving enough information during family planning counseling during prenatal period. Women perceive the counseling service is not adequate and focus on few options. Inadequate staffing, limited attendance time, client overload, the community's negative attitude towards long term family planning, and common misperceptions regarding various contraceptive modalities were the challenges in providing quality counseling. So service Providers should take in to an account the perception and preference of clients while providing family planning.
- Women who obtained used contraceptive before being pregnant received significantly better-quality counseling from providers there four, Health sector and stakeholder should strive to solve obstacles due to environment and limited providers. Services providers also should providers and all institution working on Prenatal care should take the factors associated in to consideration to maximize the Family planning up take.

References

Akman, M., Tüzün, S., Uzuner, A., Gul B., KAVAK, Z. (2010). The Influence of Prenatal Counseling on Postpartum Contraceptive Choice. The Journal of International Medical Research. 1243 – 1249, 38(4) 5.

Ali, M. Cleland, J., & Shah, I. (2012). Causes and consequences of contraceptive discontinuation: evidence from 60 demographic and health surveys. Geneva: World Health Organization.

Amour, C., Manongi, RN., Mahande, MJ., Elewonibi, B., Farah, A., Msuya (2021). Missed opportunity for family planning counseling along the continuum of care in Arusha region, Tanzania. PLoS ONE 16(7):e0250988.https://doi. org/10.1371/journal.pone.0250988

Barber, SL. (2007). Family Planning Advice and Postpartum Contraceptive Use Among Low- Income Women in Mexico. Int Fam Plan Perspect. 33:6–12.)

Belden, P. (2014). Counting contraception. Contraception 2014; 89(3):145–7.

Berwick, DM., Nolan, TW., & Whittington, J. (2008). The triple aim: care, health, and cost. Health Aff .27(3):759–69.

Bhatt B. N., Neupane, B., Karki, A., Bhatta, T., Thapa J, et al. (2021). Perceptions of family planning services and its key barriers among adolescents and young people in Eastern Nepal: A qualitative study. PLoS ONE 16(5): e0252184.

Bitzer J, Abalos V, Apter D, Martin R, Black A. (2016). Global CARE (Contraception: Access, Resources, and Education) Group. Targeting factors for change: contraceptive counseling and care of female adolescents. *The European Journal of Contraception & Reproductive Health Care*. 21(6):417–30.

Bruce, J. (1990). Fundamental elements of the quality of care: a simple framework. Stud Fam Plann, 21(2):61–91.

Bryant, AG., Hamela, G., Gotter, A., Stuart, GS., & Kamanga. G. (2015). Reasons for intrauterine device use, discontinuation and non-use in Malawi: a qualitative study of women and their partners. Afr J Reprod Health. 19(4):50–7.

Center of disease control. (2014). Providing Quality Family Planning Services: recommendations of CDC and the U.S. Office of Population Affairs, *MMWR*, 63(4).

Chaovisitsaree, S., Piyamongkol, W., Pongsatha, S., Morakote, N., Noium, S., & Soonthornlimsiri, N. (2005). One year study of Implanon on the adverse events and discontinuation. *J Med Assoc Thai*, 88(3):314–7.

Cleland, SB. Alex, E., Faundes, A., Glasier, A. & Innis, J. (2016). Family planning: The unfinished agenda. *Lancet*, 368:1810–1827.

Creswell, J. W. & Plano-Clark, V. L. (2018). Designing and Conducting Mixed Methods Research, 2nd ed., Thousand Oaks, CA: Sage Publications, Inc.

Dehlendorf C, Krajewski C, Borrero S. (2014). Contraceptive counseling: best practices to ensure quality communication and enable effective contraceptive use. *Clininical Obstetetric Gynecologyl* 2014;57:659

Donabedian, A. (1966). Evaluating the quality of medical care. *Milbank Mem Fund Q*, 4(3):166–206.

Donabedian, A. (1988). The quality of care: how can it be assessed? *JAMA*, 260(12):1743–8.

Edhs 2016

Federal Republic of Ethiopia, Ministry of Health. (2010). Management protocol on selected obstetrics topics.

Federal Republic of Ethiopia, Ministry of Health. (2011). National Guideline for Family planning services in Ethiopia.

FP2020's Annual Report. *(2020).* PP2020 Women at the Center 2018-2019.

Gaspar,AV., Silva,I, Almeida, M. (2022). Perception about Intrauterine Devices, Prior to and After Placement—Prospective Survey. *Clin. Exp. Obstet. Gynecol.* 49(4): 92)

Guttmacher Institute. (2020). Adding it up - investing in sexual and reproductive health in low- and middle-income countries. Fact Sheet. July, 2020. Available: https://www.guttmacher.org/sites/default/files/factsheet/adding-it-up-investing-in-sexualreproductive-health.pdf

Hardee, K., Harris, S., Rodriguez, M., Kumar, J., Bakamjian, L., Newman K,et al. (2014). Achieving the goal of the London summit on family planning by adhering to voluntary,

rights-based family planning: what can we learn from past experiences with coercion? *Int Perspect Sex Reprod Health*, 40(4):206–14.

Holt, K., Dehlendorf, C., & Langer, A. (2017). Defining quality in contraceptive counseling to improve measurement of individuals' experiences and enable service delivery improvement. *Contraception*, 96(3):133–7.

Hounton, S., Barros, AJ, Amouzou A., Shiferaw, S., Maïga, A., Akinyemi, A., et al. (2015). Patterns and trends of contraceptive use among sexually active adolescents in Burkina Faso, Ethiopia, and Nigeria: evidence from cross-sectional studies. *Global health action*. 8(1):29737.

Hrusa, G., Spigt, M., Dejene,T., & Shiferaw,S. (2020). Quality of Family Planning Counseling in Ethiopia: Trends and determinants of information received by female modern contraceptive users, evidence from national survey data, (2014-2018). P*LoS ONE*, 15(2):e0228714.https://doi.org/ 10.1371/journal.pone.0228714

Institute of Medicine. (2001).Crossing the quality chasm: a new health system for the 21st century. National Academies Press..

Jain, AK. (2016. Examining progress and equity in information received by women using a modern method in 25 developing countries. *International perspectives on sexual and reproductive health*). 42(3):131–40

Jain, AK., & Hardee, K. (2018). Revising the FP quality of care framework in the context of rights-based family planning. *Stud Fam Plan*, 49(2):171–9.

Jain, Ak., Aruldas, K., Tobey, E., Mozumdar, A., & Acharya, R. (2018). Adding a question about method switching to the method information index is a better predictor of contraceptive continuation. *Glob Health Sci Pract*,7(2): 289–99.

Jain, AK., Ramarao, S., Kim, J. & Costello, M. (2012). Evaluation of an intervention to improve quality of care in family planning programme in the Philippines. *J Biosoc Sci*, 44(1):27–41

Katherine. 2016. "Measuring quality of care: A review of previously used methodologies and indicators," Working Paper 2 of the Measuring and Monitoring Quality of Services and Quality of Care Project. New York: Population Council.

Laura, R., Rubio-Rico, L. Ortega-Sanz, L. Raigal-Aran, L. Flor-López, M. Alba Roca-Biosca1, et al (2021). Contraceptive counseling experiences in Spain in the process of creating

a web-based contraceptive decision support tool: a qualitative study. Reyes-Martí et al. Reproductive Health 18:237.

Lei, ZW., Wu, SC., Garceau, RJ., Jiang, S., Yang, QZ., Wang, WL., et al (1996). Effect of pretreatment counseling on discontinuation rates in Chinese women given depo-medroxyprogesterone acetate for contraception. *Contraception*, 53(6):357–61 .

Lopez, L.M., Hiller, J.E., Grimes, D.A., Cheb, M., (2012). Education for Contraceptive Use by women After Childbirth (Review). The Cochrane Library, Cochrane.)

Majlessi1, F., Banaem, LM., Shariat, M. (2011). Client and Health Workers Perceptions on Family Planning Services Iran Red Crescent Med; 13(7):469-474).

Mitchell, A. (2018). A review of the mixed methods, pragmatism and abduction techniques. *The Electronic Journal of Business Research Methods*, 16:103-116.

Ali, M., & Nguyen, T. T. (2021). Defining counseling in contraceptive information and services: outcomes from an expert think tank, *BMJ Sex Reprod Health*, 0:1–3. doi:10.1136/bmjsrh-2021-201132

Molina-Azorin, J. F. (2016) "Mixed methods research: An opportunity to improve our studies and our research skills," *European Journal of Management and Business Economics*, (25): 37-38.

Population Council. (2005). A client-centered approach to reproductive health. Islamabad, Pakistan,. Available: https://www.popcouncil.org/uploads/pdfs/CCA_TrainersManual.pdf

RamaRao, S., & Jain, AK. (2015). Aligning goals, intents, and performance indicators in family planning service delivery. *Stud Fam Plann*, 46(1):97–104.

Saka, M. J., Yahaya, L. A., & Saka, A. O. (2012) "Counselling and client provider-interactions as related to family planning services in Nigeria," *Journal of Education and Practice*, l3(5): 16–25.

Susheela, S., Darroch, JE., Ashford, LS., & Vlassoff, M. (2009). Adding It Up: The Costs and Benefits of Investing in Family Planning and Maternal And Newborn Health. *Guttmacher Institute and UNFPA.*

Teshome, A., (2017). Quality of family planning counseling among women attending prenatal care at a hospital in Addis Ababa, Ethiopia.

Tolley, E., Loza, S., Kafafi, L., & Cummings, S. (2005). The impact of menstrual side effects on contraceptive discontinuation: findings from a longitudinal study in Cairo, Egypt. *Int Fam Plan Perspect*, 31(1):15–23.

United Nations Population Network. Report of the international conference on population and development. A/CONF.171/13: Report of the ICPD (94/10/18); 1994. [Cairo].

Whiting-Collins, L., Grenier, L., Winch, P.J. et al(2020). Measuring contraceptive self-efficacy in sub-Saharan Africa: development and validation of the CSESSA scale in Kenya and Nigeria. *Contraception*: X 2 100041

World Health Organization. (2001). Information, Education and Communication.

World Health Organization. (2014). Ensuring human rights in the provision of contraceptive information and services: guidance and recommendations. Geneva.

Zafar, AN., & Humble, ME. (2006). Determinants of oral contraceptive pill use and its discontinuation among rural women in Bangladesh. *Reprod Med Biol*, 5(2):111–21.

Annex –English version

JIMMA UNIVERSITY

COLLEGE OF EDUCATION and BEHAVIOURAL SCIENCE

Department of counseling psychology

Part I – Socio-demographic and reproductive characteristics

No	Questions	Categories
01	How old are you?	------ in completed years
02	What is the highest Educational level you Completed?	Illiterate If literate --------- grade completed
03	What is your Current Marital / relationship Status?	1. Married 2. Single 3. Widowed 4. Divorced 5. Non married partner
04	What is your current Occupation?	1. House wife 2. Student 2. Daily laborer 4. Merchant 5. Private employee 6. Government employee Other (specify)----------
05	Family monthly income?	--------- birr
06	Ethnicity	1. Oromo 2. Amahara 3. Tigre Other----------
07	Religion	1. Muslim 2. Orthodox 2. Protestant 4. Other---------
08	Residential area	1. Urban 2. Rural
09	How many pregnancies have you ever had?	_____Pregnancies, No. of live births_____
10	Is the current pregnancy wanted	1. Yes 2. No
11	What was your age at your first birth	_____ years
12	Number of live children by sex	1. Male____ 2. Female_____
13	Have you ever used modern Contraceptive?	1. Yes 2. No
14	If the answer to the above is yes, which method did you use?	**1–** pill 2 - injectable 3– implant (Norplant) 4 – IUCD/ loop 5 – natural method 6. others _____
15	What was the main reason that you Stopped using contraceptive method?	1 – Fear of side effect 2 – Fear of infertility 3 – Medical problem 4 –Desire to have child 5– Little risk of pregnancy 6 – Religion prohibition 7 – Others
16	Are you planning to use contraceptive method after delivery	Yes 2. No
17	Number of ANC visit	_____

Part II- contraceptive self-efficacy

No	How certain you are that you can:	0 cannot do at all to 10 highly certain can do’
20	Discuss family size with my husband/partner	1 yes ☐ 2 no ☐
21	Discuss if and when I'd like to get pregnant again with my husband/partner	1 yes ☐ 2 no ☐
22	Discuss specific family planning methods with my husband/partner	1 yes ☐ 2 no ☐
23	Reach an agreement with my husband/partner about use of family planning that takes my desires into account	1 yes ☐ 2 no ☐
24	Bring up the topic of family planning with a health care provider	1 yes ☐ 2 no ☐
25	Ask a provider to clarify something they have told me about family planning if I'm not sure I understand	1 yes ☐ 2 no ☐
26	Tell a provider what's important to me in choosing a family planning method	1 yes ☐ 2 no ☐
27	Choose a family planning method that will work well for me	1 yes ☐ 2 no ☐
28	Obtain the method of family planning I want, if I want one	1 yes ☐ 2 no ☐
29	Obtain a different method of family planning if the one I want isn't available	1 yes ☐ 2 no ☐
201	Find solutions to bothersome side effects from family planning or switch methods if needed because of bothersome side effects	1 yes ☐ 2 no ☐
202	Use a family planning method according to instructions to prevent pregnancy	1 yes ☐ 2 no ☐
203	Stop using family planning and get pregnant again if/when I want to	1 yes ☐ 2 no ☐

Part III- Quality of FP Counseling

No	Items	Categories
30	Received FP counseling at any ANC visit	1 yes ☐ 2 no ☐
31	Did the provider ask you about your reproductive goal, i.e. how many children do you have, and how many you want?	1 yes ☐ 2 no ☐
32	Did the provider ask you about different methods you have used earlier?	1 yes ☐ 2 no ☐
33	Did the provider ask you about problems you have had with earlier methods?	1 yes ☐ 2 no ☐
34	Did the provider ask your method preference?	1 yes ☐ 2 no ☐
35	Did the provider tell you about different FP methods?	1 yes ☐ 2 no ☐
36	Did the provider explain you how to use the method you selected?	1 yes ☐ 2 no ☐
37	Did the provider tell you about possible side effects of the method you selected?	1 yes ☐ 2 no ☐
38	Did the provider tell you what to do if you experience any problem after using the method you selected?	1 yes ☐ 2 no ☐
39	Did the provider encourage you to ask questions?	1 yes ☐ 2 no ☐
40	Was the time spent in consultation sufficient to discuss your needs?	1 yes ☐ 2 no ☐
41	Did the provider treat you in a friendly way?	1 yes ☐ 2 no ☐
42	Did provider treat you in a respectful way?	1 yes ☐ 2 no ☐

43	Any time during the discussion with the health provider, did you feel that he/she is pressurizing you to select a particular family planning method?	1 yes ☐ 2 no ☐

In-depth interview guide for pregnant women

1. During any of your antenatal visits, did health care worker talk discussed about your pregnancy and related issue? If yes, on what issues? Probe Family planning

Yeroo hordoffi ulfaa kan ogeesi fayyya wee'ee maali si gorse? Waa'ee karoora maatii gorsa argatee?

2. Do you think you have received adequate information regarding family planning methods was expected? If not, what could be the reason?
   wee'ee karoora maatii gorsa ga'aa akka yedeetti argatee? Yoo lakki jeette sabaabn isaa malli?
3. Do you think the counseling provided was sufficient in aiding women's decision-making process? Probe: who make a decision about contraceptive use, yourself, your husband or provider?
   Goorsi karoora maatii irratti siif kenaame akka murtoo siiri ta;ee murteesitu si gargara? karoora maatii akka fayadmatu eenyutu siif murteesa? Offikee moo, abba manaa kee, ogeesa fayya
4. Did you receive FP brochure and if the content was explained to you?
   Bareefama wee'ee karoora maatii qabuu siif kenammera? Waa.ee qabiyye isaa sitti himameraa?
5. Are you willing to use modern contraceptive methods in the future (after delivery)? If yes, which method would you intend to use? Do you think the counseling session during your prenatal care helped you to make a decision? If yes, how? If why?
   karoora maatii garaa fuula duratti fayyadamuuf karooora qabda? Isaa kami? Gooris atti yerroo ulfaa argatee akka murtesiitu sigargareera?
6. How do you preference to receive family planning counseling during ANC if yes how?
   Gorsi wee'ee karoora maatii akkamitti osoo sifkenamme filata?
7. What makes the difference between a good and not-so-good interaction with a healthcare provider while counseling, and describe an ideal interaction?

Probes: what information should be provided by the provider? What information should be solicited from the client? Who should make the decision about which method to use? Confidentiality, Privacy, Empathy, Respect, Non-discrimination, and Trust

Wallitti dhufeenyaa durbarii fi ogeesa fayyaa kan garrii fi badaa tasiisu mallidha?

In-depth interview guide

1. How do you perceive ANC FP counseling in your clinics?
2. What are the common organizational and service-related obstacles hindering the provision of family planning counseling in your clinic?
3. How can we improve the provision of family planning counseling during ANC visit in health centre?

Appendix B: Afan Oromo Version

Waraqaa Gaaffii

Kutaa I – Gaaffilee hawaasummaa, dinagdee fi wal-hormaata

Lk	Gaaffii	deebii
01	Umriin keessan meeqa?	wagaa------
02	Sadrkaan barnoota keessanii meeqa??	1. hin barannee 2. barreessufi dubbisuu qofa Sadarka ---------
03	Haala fuudha	1. Waliin jiru 2. Wal-hiikaniiru 3. Irraa du'e 4. Addaan bahan 5. Qofaa
04	Hojiin keessan maalii?	1. Haadha manaa qofa 2. Qotee bulaa 3. hojjetaa mootummaa 4. Hojjataa dhuunfaa 5 daldalaa 6 hojjataa guyyaa 96 kan biraa ibsi
05	Ji'aatti galiin keessan meeqa ta'a ?	Qarshi _____ 99 hin beeku
06	Qomoon keessan maalii?	2. Oromo 2. Amahara 3. Tigre Kan bir ibsi----------
07	Amntiin keessan maalii?	3. Muslim 2. Orthodox 4. Protestant 4. Other---------
08	Teessoo	2. Magalaa 2. Baadiyaa
09	Ulfi kun meqeefa keeti?	_____
10	Ulfi kun ni barbadama ykn keroorfamadha	2. Eeyye 2. Lakki
11	Yeroo mucha kee isa jaalqabaa deessu, umuurin ke meeqa ta,a?	wagaa_____
12	Lakkoofsi ijoole kee meeqa?	Dhiira____ Dubara_____
13	Qoricha ulfa **dhowwutti** fayyadmitee ni beekata?	2. Eeyyee 2. Lakki
14	Isa kami fayyadamtee?	**1 –** Kiniinii 2 – Kan harka irra awalamu 3 – Marfee ulfaa 4 – kan gadameesa keesaa galu Kan birra ibsi_____
15	Maaliif addaan kutte?	1 – Rakkoo natti waan fideef 2 – Nama maseensa jedheeasn sodachu 3 – Rakko fayya 4 – Daa'ima argachuuf 5 – saaxilamaa ulfaa xiqachhu 6 – Amantaan waan dhoorkuuf 7 – kan biraa ibsi
16	Yeroo deessee kaatu, qoricha ulfa **dhowwitu** fayyadamuuf karoora (karoora maatii qabda?	1 eeyee 2 lakkii
17	Hordoof yeroo ulfaa yeroo meqaafa keeti?	_____

Kutaa 2- Offitti hamanammuma karoora maatii fayyadamu

No	How certain you are that you can:	1. Eeyyye 2.
20	Waa'ee karoora maatii abbaa manaa kee waliin in mari'atta?	1 Eeyee 2 Lakki

21	Yeroo daa'ima da'uu barbadu abbaa manaa kee bilisaan ni mari'atta?	1 Eeyee	2 Lakki
22	Mala karoora maatii gosa fuchuu barbaddu abbaa manaa kee bilisaan ni ibsitaa?	1 Eeyee	2 Lakki
23	Mala karoora maatii fedha kee guutuu fudhachu barbadu abba manaa ke faana ni dubatta	1 Eeyee	2 Lakki
24	Waa'ee karoora maatii kaastee hojjeeta fayyaa waliin in dibatta?	1 Eeyee	2 Lakki
25	Waa'ee gosa karoora maatii faayyadamuu barbaadu kan siif hin galiin ni gafata?	1 Eeyee	2 Lakki
26	Yeroo karoora maatii filatu wan bayyee barbachisa ta'e ogeesatti ni himtaa	1 Eeyee	2 Lakki
27	karoora maatii akka siriiti fayadamuu in dandessa		

Kutaa 3- Qulquliina marii karoora maatii

No	**gaaffi**	**deebi**
30	Yeroo hordoffi ulfaa kan wee'ee karoora maatii gorsa argatee?	1Eeyye ☐ 2Lakki ☐
31	Ijoolee meeqa akka qabachuu barbaaddu sigaafateraa/tti?	1Eeyye ☐ 2Lakki ☐
32	karoora maatii kami akka fayyadamaa turte sigafattera?	1Eeyye ☐ 2lakki ☐
33	Yeroo fayadama turtee, rakko akkamitu si qunamma ture?	1Eeyye ☐ 2Lakki ☐
34	Ogeesi fayya filanoo kee si gafatera?	1Eeyye ☐ 2Lakki ☐
35	Waa'ee karoora maatii gosa adda adda sif ibseera?	1Eeyye ☐ 2Lakki ☐
36	karoora maatii isa atti filate akkamitti akka fayyadamtu sitti himeera?	1Eeyye ☐ 2Lakki ☐
37	Ogeessi fayyaa rakkoo ykn midhaa siqunammu danda'u siif ibsitteti?	1Eeyye ☐ 2Lakki ☐
38	Yeroo karoora maatii fayyaadamtu yoo akka tasa rakkon siqunamee maali akko gochu qabdu ogeessi fayyaa sitti himeera/tti?	1Eeyye ☐ 2Lakki ☐
39	Ogeessi fayyaa akka ati gaafii gaafattuf si kakkaaseera?	1Eeyye ☐ 2Lakki ☐
40	Yeroo isin waliin marii taasistan gahaa ykn quubsaa dha?	1Eeyye ☐ 2Lakki ☐
41	Ogeessi fayyaa karaa haala hiriyummaan tajaajila sif kenne ?	1Eeyye ☐ 2Lakki ☐
42	Ogeessi fayyaa kabajaan si tajaajilee?	1Eeyye ☐ 2lakki ☐
43	Akka atti karoora maatii tokko fayyaadamtuuf si dirqisiisee?	1Eeyye ☐ 2Lakki ☐

Appendix C: Interview Guide

Gaafii gadifageenyaa

1. Yeroo hoordoffi ulfaa kan hojeetan fayyaa wee'ee maali si gorse? Waa'ee karoora maatii gorsa argatee?
2. Wee'ee karoora maatii gorsa ga'aa akka yeddeetti argateeta? Yoo lakki jeette sabaabin isaa maali?
3. Gorsi karoora maatii irratti siif kenaame akka murtoo sirri ta'ee murteesitu si gargareera? Karoora maatii akka fayyadamtu eenyuttu siif murteesa? Offikee, abbaa manaa kee, hojeeta fayyaa?
4. Barreefama wee'ee karoora maatii qabuu siif kenammeraa? Waa'ee qabiyye isaa sitti himameraa?
5. Karoora maatii gara fuula duratti(deesee) fayyadamuuf karooora qabda? Isaa kami? Gorsi atti yerroo ulfaa argatee akka murtesiitu sigargareera?
6. Gorsi wee'ee karoora maatii akkamitti osoo sifkenamme filata?
7. Wallitti dhufeenyaa durbarii fi ogeesa fayyaa kan garrii fi badaa tasiisu mallidha?