ASSESSMENT OF QUALITY OF CONTRACEPTIVE COUNSELLING SERVICES IN PUBLIC HEALTH FACILITIES OF ZAMFARA STATE

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DECLARATION

I declare that the work in this dissertation entitled "*Assessment of Quality of contraceptive counsellingServices in Public Health Facilities of Zamfara State"* wascarried out by me in the department of Nursing Sciences. The information derived from the literature has been duly acknowledged in the text and a list of references provided. No part of this dissertation was previously presented for another degree or diploma at this or any other institution.

_____ _____ _____

Name of Student Signature Date

CERTIFICATION

This dissertation entitled "ASSESSMENT OF QUALITY OF CONTRACEPTIVE COUNSELLINGSERVICES IN PUBLIC HEALTH FACILITIES OF ZAMFARA STATE" by AMINA AHMAD meets the regulations governing the award of master degree in nursing sciences of the Ahmadu Bello University, and is approved for its contribution to knowledge and literary presentation.

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DEDICATION

This project work is dedicated to my late parents Alhaji Ahmadu Sallah and Malama AsiyaJibril. May their gentle souls rest in perfect peace and may jannatulfirduas be their final home.

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ABSTRACT

Contraceptive counselling for rightful decision making in family planning methods selection is one important reproductive right of a woman. The study aimed to assess quality of contraceptive counselling services in public health facilities of Zamfara state. The study identified the number of formally/certified FP trained service providers, assessed quality of contraceptive counselling, identified number of client‘s offered, pattern of contraceptive method mix in the last six month preceding the study and client‘s satisfaction with service provision. A concurrent mixed method study design (qualitative and quantitative) method was employed for the study. Seven (7) public health care facilitiesout of the 22 available hospitals were selected for the study through multi-stagesampling technique from which 48 clients were interviewed. The tools for data collectionwere an observation guide and an interview checklist adopted from Kim (1995) used to elicit responses of the respondents via overt non-participant observations during counselling sessions, client exit interviews and clients` satisfaction with the service provision. Service delivery registers of the selected facilities were scrutinized for availability of contraceptive method mix in the last six months prior to survey. The number of formally trained FP providers in the selected facilities was obtained from the state MCH coordinator and corroborated at the facilities from the respective head of the FP clinics. Data from Client Exit Interview (CEI) was transcribed in Hausa and translated into English by a translation expert which was subsequently analysed manually using thematic content methodology. The reports from the observations of the counselling sessions were coded and also analyzed manually. The data on contraceptive method mix was analyzed using excel spread sheet 2010 and presented in a table and simple percentages. Pearson correlation coefficient was used to test relationship between variables at p-value of 0.05. Findings revealed that most of the respondents are within the reproductive age 20-39 years with range between 4-6 parity haven the highest % of 39.5. Majority had secondary education and all were married (100%). The quality of client-provider interaction was found to be poor as evaluated by the researcher and reported by the respondents. Trained service providers were in short supply with 50%. Nearly 4,000 clients were offered various contraceptive method mix in which the injectable was the commonest method accounting for one quarter of these clients followed closely by the implant with 34.7%, despite poor client-provider interaction, clients were still satisfied

with some aspect of counselling such as greeting, provision of free contraceptive and information they received from their service providers. Correlation was seen between various subset of the client satisfaction and socio-demographic characteristics; occupation and parity were found to be correlated with counselling session (p=0.012) and (0.050) respectively. The findings suggest the need for increase awareness and enlightment on FP counselling to women through mass media, mass employment by the government to address shortages and the need for FP providers to be specifically trained on contraceptive counselling techniques to improve the quality of FP counselling services in public health facilities in Zamfara state.

Key: ServiceQuality, Contraceptive Counselling, Method Mix, Service Providers

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ABBREVIATIONS

ACQUIRE	Access Quality and Use in Reproductive Health
AIDs	Acquired Immunodeficiency Syndrome
AIOM	American Institute of Medicine
ANMs	Auxiliary Nurse Midwives
BCS	Balanced Counselling Strategy
CEI	Client Exit Interview
CDC	Center for Disease and Control
CHEWS	Community Health Extension Workers
COC	Combined Oral Contraceptive
CPI	Client-Provider Interaction
DMPA	Depot Medroxyprogesterone Acetate
DMT	Decision Making Tool
DRC	Democratic Republic of Congo
FDA	Food and Drug Administration
FGN	Federal Government of Nigeria
FMOH	Federal Ministry of Health
FP	Family Planning

HIV	Human Immune Virus
HMIS	Health Management Information System
IEC	Information, Education and Communication
ICF	Intermediate Care Facility
IPPF	International Planned Parenthood Federation
IUCD	Intrauterine Contraceptive Device
IUD	Intra Uterine Device
KFWCH	King Fahad Women and Children's` Hospital
LAM	Lactational Amenorrhea Method
LAPMs	Long Acting and Permanent Methods
LARCs	Long Acting Reversible Contraceptives
NIS	National Institute of Statistics
OCPs	Oral Contraceptive Pills
PHC	Primary Health Care
SDGs	Millennium Development Goals
SDPs	Service Delivery Points
STDs	Sexually Transmitted Diseases

STIs	Sexually Transmitted Infections
TDHS	Tanzanian Demographic Health Survey
UNFPA	United Nations Population Fund
USAID	United State Agency for International Development
USPSTF	United State Preventive Services Task Force
WHO	World Health Organization

DEFINITION OF TERM

Counselling: Is defined as the exchange of information between a provider and a client that helps the client reach an appropriate decision and act on it.

Formally/Trained Service Provider:refers to any male or female staff who acquired a comprehensive training on one or more than two methods of family planning by NGOs or in a recognized training institution provided mainly for that purpose.

Method Mix: refers to the number or percentage (%) of women utilizing a particular contraceptive method in a giving population (i.e., the percentage that uses each method).

Public Health Facilities: Secondary health care facilities in Zamfara state.

Quality Contraceptive Counselling Services:these are services provided by health care service providers in FP unit, these includes; greeting, assessment, history, client-provider interaction, environment, client satisfaction and follow-up.

CHAPTER ONE

INTRODUCTION

1.1 Background of Study

Nigeria is one of the seven most populous nations in the world which has a current estimated population of 206 million, which is projected to reach 402 millionby 2050, (United Nations, 2020). There are an estimated 40 million women of reproductive age in the country, with an annual number of births of approximately 7 million and annual population growth of 3.2% per annum (United Nations, 2018). The country's rapid population growth is attributable to a high Total Fertility Rate (TFR) of 5.5 children per woman, (National Population Commission and Intermediate Care Facility (ICF) International, 2014). The resultant high fertility is a significant contributor to high maternal mortality in Nigeria. Even though Nigeria has only 2% of the global population, it contributes a disproportionate 15% to the global burden of 303,000 annual maternal deaths (World Health Organization (WHO), 2015).

When women have access to family planning, everyone benefits. Women and children are healthier, families and communities can invest more in education and health care and poverty is reduced, (Population Council, 2016). Strengtheningfamilyplanningservicesiscrucialtoimprovinghealth,humanrights,economic development,andslowingpopulation growth, (National Population Commission and ICF International, 2014). Study conducted by (Tessema, Steak, Mahmood, & Laurence, 2016), have showed that up to 40% of maternal deaths could have been averted through use of family planning services, the study further stated that in 2015, 64% of married or in union women of reproductive age were using some form of contraception in the

world but the use was much lower in Africa (33%).It is estimated that globally, 214 million women of reproductive age in developing countries who want to avoid pregnancy are not using a modern contraceptive method. In Africa, 24.8% of women of reproductive age have an unmet need for modern contraception (Family Planning (FP) 2020, 2018).

According to the latest National Demographic Health Survey (2018), about 19% of young married women in Nigeria reported having an unmet need for Family Planning (FP), and about 48% of sexually active unmarried women reported having an unmet need. The proportion with unmet need translates into more than 1,383,000 women, (Nigeria Demographic and Health Survey (NDHS), 2018).

Over the years, women remain the vulnerable group whom through the process of procreation end up with different forms of debilitating diseases, infections, disabilities and mortality. Provision of good quality contraceptive counselling service is vital to reducing unmet need for family planning. The utilization and availability of family planning services protect the health of women and their family by providing enough birth interval and preventing unplanned pregnancies.Effectiveness of family planning programs is determined by inclination in contraceptiveprevalence among a population as well as the ability of the programs to attract more clients and retainthem over time, (American Institute of Medicine (AIOM) 2014).

Quality of services is an important determinant of continuity of contraceptive utilization by clients (Hancock, Stuart, Tang, Chibwesha & Chi, 2016).. Recent recommendations have once again brought the issue of program quality back to the forefront of family planning policy and programs, (Hancock, et.al, 2016). Quality is a corner stone of the World Health Organization‘s right-based approach to family planning and United State

Centre for Disease Control (CDC), reproductive life planning and provision of family planning services, (Hancock, et. al, 2016).

American Institute of Medicine, (AIOM) (2014) defines health-care quality as the extent to which health-care services improve health outcomes in a manner that is consistent with current professional knowledge.

Quality can be seen as a means of providing services that address the reproductive needs of women in a way that upholds their rights and enables them to gain control over their reproductive capacity. Clients' utilization or non-utilization of family planning services are based on a number of factors including perceptions of facility quality and access to high quality services, (Access, Quality and Use Reproductive Health (ACQUIRE) Project, 2008). Reproductive health outcomes would only be improved when quality of family planning services is adequate.

Counselling is one of the critical elements in the provision of qualityfamily planning services. Through counselling, providers help clients make and carry out their own choices about reproductive health and family planning (Solter, 2013). Good counselling leads to improved client satisfaction. A satisfied client promotes family planning, returns when she/he needs to and continues to use a chosen method, (Solter, 2013).In most of Sub-Saharan Africa, Nigeria inclusive, quality of contraceptive counselling services still remain low and unmet need of family planning remains high, equal amounts of information on each method during counselling were not provided, limited information was provided on how to use, side effects, effectiveness and contraindications, (Askew, Mensch and Adewuyi, 2016). In most of the Service Delivery Points (SDPs), few Information Education and Communication (IEC) aids

were used and group health talk were a common method of imparting information by service providers,(Askew, et.al, 2016).

Studies conducted worldwide by Access Quality and Use Reproductive Health (ACQUIRE)Project (2008), and others, (Leon, 2008) have repeatedly shown that the quality of family planning counselling is weak because providers' skills are inadequate. This is not surprising, since the skills-building component of training for counsellors is usually kept short and sometimes is even skipped (Hancock, et.al, 2016). Counselling training traditionally focuses on addressing the needs of new clients. In their effort to provide information, many providers end up giving clients too much information. The communication is usually one-way. Clients are not prepared for what side effects to expect or for what to do when those side effects occur, (Leon, 2008). Improving quality of contraceptive counselling services is an essential step in helping women to make an informed choice on contraceptive. Despite renewed interest, recent published data assessing quality counselling in family planning are limited, especially in resources-constrained settings where unmet need may be greater (Hancock, et.al, 2016).

1.2 Statement of the Problem

Improving the quality of contraceptive counseling services is one strategy to prevent unintended pregnancy.With more than 175 million people, Nigeria is the most populous country in Africa, (Nigeria Family Planning Blueprint, 2014) with annual population growth of 3.2 percent, and the total fertility rate of 5.5, with variations across states and regions from 4.3 children per woman in the South Zone to 6.7 children per woman in the North West Zone, (Nigerian Demographic Health Survey (NDHS), 2018). Most projections place Nigeria as the third most populous country behind India and China by

2050, (Nigeria Family Planning Blueprint, 2014). The rate of modern contraceptives use ranges from 3% in the North East Zone to 25% in the South West Zone.

According to Nigerian FP2020 core indicator`s fact sheet, (2018) unmet need for modern contraception is 24.8% in 2018 and this is projected to reach 25.2% by 2020.

In Nigeria, number of unintended pregnancies in 2018 was 1,371,000 (Nigeria FP2020 fact sheet, 2018) and total discontinuation rate of both long acting and short acting contraceptives was 87.4% (NDHS, 2018). Nonuse of contraceptive methods, use of less effective methods, and incorrect and inconsistent use of methods underlie the high frequency of unintended pregnancy (Dehlendorf, Krajewski and Borrero, 2014). Approaches to optimizing women's experiences of contraceptive counseling include working to develop a close, trusting relationship with patients and using a shared decision-making approach that focuses on eliciting and responding to patient preferences. Providing counseling about side effects and using strategies to promote contraceptive continuation and adherence can also help optimize women's use of contraception (Dehlendorf, et.al, 2014).

Providers have the potential to positively influence women's ability to use contraception during health care visits. In addition, several prospective studies in the developing world have used composite measures of counseling, including measures of both relational and task-oriented aspects of communication, and have found that women who report experiencing higher quality care have higher rates of contraceptive continuation(Dehlendorf, et.al, 2014). Studies have also found that provision of information about side effects specifically is associated with improved outcomes (Dehlendorf, et.al, 2014).

In more recent times, the Federal Government of Nigeria (FGN) took urgent steps towards creating the required favourable and conducive environment for the delivery of

and access to high-quality health services by Nigerians in their different localities. Some of these steps included the policy on free contraceptives, accelerated implementation of activities around the Long-acting Reversible Contraceptive (LARC) methods and improving contraceptive services generally. Studies using observation of family planning encounters have been conducted in both the developing and developed world. With respect to quality of contraceptive counselling, studies have documented that, across settings, the interaction is often provider-dominated, with minimal engagement between women and their providers in the process of method selection and with frequent failure of providers to deliver personalized counselling tailored to the individual women's needs and preferences, (Dehlendorf, et.al, 2014).

Similarly, a qualitative study conducted in Tanzaniaby Leon, (2008) reported that in the counselling processfamily planning providers pay too much attention to irrelevant methods and relatively little to the method chosen by the client, leading to high discontinuation rate and probably the selected method not well understood by the clients.Most of the counselling time is spent describing numerous method options. Important information for both provider and client such as contraindications, side effects, and warning signs related to the chosen method are neglected, (Bruce, Linda, and Martin. 2008).

Women want to develop confidence with their providers and also want to receive comprehensive information about options, particularly about side effect. Observational studies support the importance of the provider-client interaction in family planning, despite the provider-client interaction, attempt to improve contraceptives use through counselling interventions have had limited success(Bruce, et.al. 2008).A study obtained qualitatively by Bruce (1990 as cited in Askew 2016), found that clients who are willing to practice family planning would be discouraged if not given enough

information that can be used or if methods are limited. Human behaviour is generally affected by what people know. Knowledge about contraception should be an important predictor of contraceptive use (Askew 2016). Contraceptive counselling has great potential as a strategy to empower women who do not desire pregnancy to choose a method of birth control that they can use correctly and consistently over time, thereby reducing the individual risk of unintended pregnancy. The reasonable assumption would be that the more women know about contraceptives, the more they would use them. It has been observed that most of the studies conducted on family planning in northern Nigeria were tailored towards assessing family planning utilization, contraceptive uptake and attitude of clients, fertility preferences, knowledge, behaviour, unmet needs and service delivery. Studies on quality of contraceptive counselling were under researched in the study area therefore, the need for this study.

The disparity between standard of competences and what is practice in most of the public family planning facilities need to be addressed, there is an identified need for promotion of FP uptake through counsellingtherefore, the study assessedthequality of contraceptive counsellingservices in public health facilities ofZamfarastate.

1.3 Significance of the Study

It is hoped that result from the study will help to improve the quality of care of contraceptive services in the following ways:

Result from this study will add to the body of knowledge in the state since there are no documented relevant/similar studies carried out in the state. Findings from this study will inform service providers' nature of the problem in existence and strategies ways of improving the scope of the service delivery which will in turn promote increase uptake of family planning services by women. Result from this study will as well inform

policy makers on the existing nature of services rendered thereby guiding policy formulation that has to do with family planning services. Result from the study will bring about healthy population of women of reproductive age which will in turnpromote economic growth and development of the nation. The result will provide basis for conduct of further research in the area.

1.4 Aim and Objectives of the Study

The main aim of the study is to assess quality of contraceptive counselling services in public health facilities of Zamfara state.

Specific objectives:

1. To identify the number of formally trained/certified family planning service providers in the selected public health facilities of Zamfara state.
2. To assess quality of counselling for contraceptive services in selected public health facilities ofZamfara state.
3. To determine the number of clients servedwithpattern of contraceptives method mix for six month prior to survey in the selected public health care facilities of Zamfara state.
4. To assess clients‘satisfaction with contraceptive counselling services provided in public health care facilities of Zamfara state.

1.5Research Questions

1. Whatare the numbers of formally trained family planning service providers in selected public health care facilities of Zamfara state?
2. What is the quality of counselling of contraceptive services in public health care facilities ofZamfara state?

3. What are the number of clientsserved with and the pattern ofcontraceptive method mix for six month prior to survey in the selected public health care facilities of Zamfara state?
4. What is the level of clients‘satisfaction with contraceptive counselling services provided in public health care facilities of Zamfara state?

1.6 Hypothesis

There is no significant relationship between socio-demographic characteristics of client (women) and client satisfaction.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction:

In this chapter, various literature were reviewed based on the following; number of formally/certified trained service provides, quality of contraceptive counselling service provision, method mix in contraception, clients satisfaction with counselling services and theoretical frame work.

2.1 Contraception and maternal health

Family planning programs play an important role in maternal health and **thepopulation health generally, provision of high-quality contraceptive information and services is essential to achieving the highest attainable standard of health for all, including sexual and reproductive health (Marquez and Kean 2012). It is recognized that this cannot be done without respecting, protecting and fulfilling the human rights of all individuals.Reproductive health programs are more effective when clients believe that their needs are met and that they are treated well (Marquez and Kean 2012).**

2.2Formally Trained Personnel

Individuals have the right to be fully informed by appropriately trained personnel. Health-care providers have the responsibility to convey accurate, clear information, using language and methods that can be readily understood by the client, together with proper, non-coercive counselling, in order to facilitate full, free and informed decision-making. The information provided to people so that they can make an informed choice

about contraception should emphasize the advantages and disadvantages, the health benefits, risks and side-effects, and should enable comparison of various contraceptive methods. Censoring, withholding or intentionally misrepresenting information about contraception can put health and basic human rights in jeopardy, (Stanback, Steinesr, Dorflinger, Solo and Willard, 2015).

Health care providers also may have knowledge deficits that can hamper their ability to offer appropriate contraceptive methods to their patients. For example, many clinicians are uncertain about the risks and benefits of IUDs and lack knowledge about correct patient selection and contraindications (Luchowski, Anderson, Power, Raglan, Espey and Schulkin, 2014). There is a major shortage of skilled providers for delivering family planning services, especially for injectables and LARCs. In the case of injectables, the policy to allow Community Health Extension Workers (CHEWs) to deliver them was approved in 2012 (Nigeria family planning blueprint, 2014), but few CHEWs have received formal training on how to deliver the method properly (i.e., provide the necessary counselling, screen for pregnancy, and deliver the actual injection).

Regarding LARCs, implants were introduced on a larger scale in the public sector only in 2006, and it is possible that many providers who received training are no longer practicing in the public system. If a provider has not been trained and does not feel confident and/or comfortable about a particular method (e.g., inserting an IUD or giving an injectable), she/he is less likely to offer that method. This contributes to provider bias for certain methods over others. The United Nation Population Fund (UNFPA), (2015) estimates that 63 percent of state hospitals in Nigeria are not offering implants. High turnover also persists in the healthcare sector. Turnover among providers can be as high as 40 percent per year in some areas of Nigeria. Doctors,

nurses, and midwives choose to leave their posts each year due to opportunities abroad, interest in other fields, or retirement(Nigeria family planning blueprint, 2014). Many experienced family planning providers also cite the lack of continuing education and training as a challenge, pointing to the 1980s as the last time that large-scale family planning training efforts were in place. Given the substantial time that has passed since then, it is likely that many of these learned skills no longer remain in the system, (Nigeria family planning blueprint, 2014).In the North, Nigerians rely on CHEWs as the primary point of care. They often work as the only staff members of PHCs, providing all the care in the community and sometimes delivering services for which they are not properly trained. Human resource density according to (Nigeria family planning blueprint, 2014) shows a low density of health care providers in Zamfara state with nurses/midwives accounting for 252 and CHEW 500.

In a study conducted by Omu, (2006) among high parity pregnant women in Nigeria revealed that 71% of the women in the intervention group are using effective method as compared to those in the control group 51%, this was mainly due to specific training undergone by staff who counselled those in the intervention group. Well trained staff will utilise health education resources to communicate contraceptive information, participants were randomized to receive educational material either pamphlets or audio-visual program with a familiar or unfamiliar narrator, or oral presentation by a physician or a combination of all the 3. Participants gained less knowledge from oral presentation by a physician provider as compared to that of audio-visual presentation with a familiar or unfamiliar narrator, understanding was high among those who received a combination of resources compared to those who received pamphlet alone, (Omu, 2006).

When service providers are professionally trained to provide quality counselling, clients are more likely to return for follow-up and continuation rate increases significantly. Formally trained health care providers can use tools such as medical eligibility criteria and decision making tool to improve quality of care, training health care workers to educate women dramatically cut the number of unplanned pregnancies among women seeking family planning services. In a study conducted by Rabb, (2006), assert that training of service providers designed by Policies for Research and Innovations in the Move (PRIME) in Tanzania using low-technology materials, short and centralized group training on-site and a simple handbook and series of audiotapes, has doubled the overall contraceptive prevalence rate, rising in five years from 6% in 1991/92 to 12% in 1996. Result shows that, the health attendants who participated in PRIME's program clearly increased their family planning knowledge over the course of the training. They gained skills in assessing and counselling family planning clients for informed choice. At facilities with trained health attendants, the number of clients served with DepoProvera® and condoms doubled, while little changed during the same period of time at comparison sites. The stakeholders' consensus was that the training approach and materials were both effective and appropriate for the cadre of Tanzanian health attendants.

Studies have revealed that due to lack of training, service providers tend to dwell on certain methods and neglecting other method such as LARC (Kim, 2011).Similarly in a national survey conducted among physicians who offers contraceptive services, only 38% provide contraceptive offers for IUDs to adolescent, 53% offers them to women without children and 25% offers them immediately after abortion, (Kim, 2011).Clients considered service providers as a source of highly trusted information on family

planning, so it's essentially important service providers inform women about all of the methods they can use and this is achieved only through training.

In a study to assess family planning use in Bauchi and Sokoto States, virtually all facilities had at least three providers who were trained in family planning. Some of the facilities had just two or even just one family planning provider. A provider in a PHC in Sokoto mentioned that "it is just me who has been trained on family planning." Some of those who had the trainings also trained other staff in their facilities to provide family planning to clients. A provider in an urban area of Sokoto explained that "I know only three people in this facility that trained and when they came back, they taught me how to insert and how to give family planning." In some facilities, there was a reduction in the number of staff trained to give family planning services (United Nation, 2013). Some of the reasons given for this reduction included relocation due to marriage and transfers to a different facility. A provider reported that, "I cannot recall because then we were many, up to ten, but due to transfers we are only three (Bessinger and Bertrand, 2011).A recent literature review concluded that training interventions on providers can improve the quality of care and produce immediate as well as long-term positive outcomes for clients, (RamaRao and Mohanam 2013).

Health care providers also may have knowledge deficits that can hamper their ability to offer appropriate contraceptive methods to their patients. For example, many clinicians are uncertain about the risks and benefits of IUDs and lack knowledge about correct patient selection and contraindications (Luchowski, Anderson, Power, Raglan, Espey & Schulkin, 2014). Improving health care provider and patient knowledge about contraceptive methods would improve access and allow for safer use. As the main point of contact between clients and the health care system, providers need various types of support in order to deliver high-quality care(Luchowski, et.al, 2014). The International

Planned Parenthood Federation (IPPF), (2013) requires that clients be offered method choice, safe contraceptive practices, privacy, confidentiality, dignity, comfort, and continuity of care. To ensure that clients receive these elements of quality services, providers need the appropriate knowledge, skills, supplies, clinical environment, and motivation.

2.3 Quality of counselling in contraceptive services

The purpose of family planning counselling is to help the client make informed choices about reproductive health and family planning issues. Family planning counselling which covers knowledge transfer about contraceptive mode of action, by enabling informed choice, improves compliance to and efficiency of contraceptive methods, (Topseverfiliz, Aladag, Topalli, Cigerli and Gorpelioglu,2006).

Clients want to receive information that is relevant to their needs, desires, and lifestyles. Because clients differ in their reproductive intentions, attitudes about family planning, ability to make decisions, and other factors that affect contraceptive choice, they need information that is tailored to their individual needs. Clients who are well-informed and have made their choice about a contraceptive method may not want detailed information on a range of other methods. Others may want information about procedures, treatment, risks, and side effects.

Assessing each client's needs and tailoring counselling to address those needs is the main goal of the Family Planning counselling service. The primary objective of counselling in the context of family planning is to help people in deciding on the number of children they wish to have, and when to have them, as well choose a contraceptive method that is personally and medically appropriate, (Solter, 2013). Appropriate counselling contributes to the successful use of family planning methods,

which contributes to personal well-being and programmatic success, (Access Quality and Use Reproductive Health(ACQUIRE) Project, 2008). Through counselling sessions, women will understand how to use their chosen method correctly, to ensure safe and effective contraceptive protection. Counselling allow the health care provider to recognize the client as a whole person with a range of interrelated Sexual and Reproductive Health (SRH) needs. These needs include correct and appropriate information; help with decision making, and emotional support. The selection of a Family Planning method must be made with consideration of a client's circumstances and other SRH issues, including the client's risk for HIV and other Sexually Transmitted infections (STIs), HIV status, reproductive intentions and pregnancy/obstetric history, and sexual relationship(s) and practices, (Access Quality and Use Reproductive Health (ACQUIRE) Project, 2008).

According to The ACQUIRE Project (2008), several countries have reached a plateau in contraceptive prevalence rates, as well as having a high level of contraceptive discontinuation. These facts suggest that counselling needs to be reoriented and refocused to: Offer a tailored approach to meeting clients' individual needs, address the needs of returning clients, strengthen management of side effects, strengthen integration with other areas of sexual and reproductive health including HIV and other sexually transmitted infections, post abortion care, and sexuality.

The quality of family planning services is an important factor that may affect contraceptive acceptability and continuation. According to Blanc (2002) as cited in (Halpern, Lopez, Grimes and Gallo, 2011) within the first year of starting a method, 7% to 27% of women stop using contraception for reasons that could be addressed during family planning counselling, including side effects and health concerns related to the contraceptive method. Quality of services is defined by provider skills, quality of

information provided, client-provider interactions, and continuity of care (Jain1989; Blanc 2002; ARHP 2004 as cited in Halpern, Lopez, Grimes and Gallo, 2011).

In a survey reported by (Khadka and Amin, 2015), revealed that the availability of supplies, commodities and essential functioning infrastructure for voluntary family planning services varied both by type of facility and district. Most of the facilities had adequate light source, availability of water and soap, separate room for counselling. All the facilities had separate room for clinical examination and procedure and a few facilities had separate toilet for clients and staff and separate instrument processing room and autoclaving area.

The lack of basic infrastructure significantly affects the quality of service and care being provided in a summary report of quality care conducted in Bihar, Indian by (Achyut, Nanda, Khan and Verma, 2015). The study showed that while certain aspects like water and electricity had improved in the health facilities, certain critical gaps remained in areas such as; areas designated exclusively for examination or counselling, consultations were quick and often cursory. Being counselled or examined in public view is bound to make women uncomfortable and impair the process of receiving and processing information. It is also likely to hamper the provider-client relationship. The report further stated that some facilities lacked simple essentials, such as scissors and narrow forceps. Gloves, dry gauge/cotton swabs and urine pregnancy test kits were also out of stock in some of the facilities at the time of the survey.

More than 90 percent of facilities ensure privacy for family planning counselling sessions and have individual client health cards available. Guidelines and protocols for family planning are not widely available(Achyut, et.al, 2015). Items for infection control are available in the family planning service area in less than one third of facilities, with soap and running water being the items most commonly lacking. Only

14 percent of facilities (mostly hospitals) have the capacity to properly process reusable family planning equipment. Only 5 percent of facilities have all of the furnishings and equipment needed for good pelvic examinations because of a general lack of examination lights and vaginal speculums. Most facilities offer privacy and an examination bed, (National Institute of Statistics (NIS), 2008). Nearly all facilities offering family planning methods containingestrogen have blood pressure equipment available. Sterile needles and syringes are available in about two-thirds of facilities offering injectable contraceptive methods. Up-to-date family planning client registers are available in about 9 in 10 facilities, mostly in government and government-assisted facilities, (NIS, 2008).

Wall (1998) as cited in (Nangendo, 2012), identified a combination of factors that obstruct contraceptive knowledge, adoption, and utilization among Hausa women in northern Nigeria. He asserted that few Hausa women have any knowledge of birth control and they consider family planning as the moral agnate of murder. This is because birth is an antidote for bereavement in the Hausa cultural society and children are considered a divine benefaction. Children are the desired outcome of any Hausa marriage, and giving birth is traditionally viewed as the greatest fulfillment of being a woman (Wall, 1998: Nangendo, 2012). Such cultural beliefs and sentiments may render the adoption and use of contraceptive methods difficult in many sub-Saharan African communities.

In a similar study carried out by (Eze and Hope, 2014) in Adankolo town of kogi state in Nigeria, women have seen the need for birth control but cultural, religious and gender factors still obstruct full implementation even among the literates.

2.3.1 Client-Provider Interaction (CPI)

From a human welfare perspective, all clients, no matter how poor, deserve courteous treatment, correct information, safe medical conditions and reliable products. It also has been argued that providing such quality services will lead to increased service utilization by more committed users, eventually resulting in higher contraceptive prevalence and lower fertility, (Williams and Schutt-Aine, 2008).

The quality of contraceptive counselling, commonly known as Client-Provider Interaction (CPI), is highly variable. Low-quality CPI is particularly problematic because the counselling process influences clients' perceptions of the quality of care, their knowledge and decision-making processes. CPIs can be marred by obstacles such as unnecessary medical barriers, provider biases, discomfort with discussing sexuality and sexual issues, and difference in status between the provider and client. Status differences between clients and providers can influence quality of care, although providers' reactions may differ by region.

TheCPI encompasses both the process (how clients are treated and whether they actively participate) and the content (what they are told or not told, technical competence, accuracy of information, provision of essential information) of a consultation. Poor client-provider interaction, therefore, can lead to clients not having essential information to choose an appropriate method; not getting the method they want; not learning what they need to know about how to use the method or how to cope with side effects; not being aware that they can switch methods if their current one is unsatisfactory; not being satisfied with their method; and ultimately, not achieving their fertility goals, due to contraceptive failure or discontinuation, (Okullo and Okello, 2003).

Improved CPI can improve health outcomes by creating more knowledgeable and satisfied clients. Successful family planning counselling requires well-trained and engaged providers and active client participation, (Loen, 2008).

In Nigeria, for example, clients of nurses trained in interpersonal relations and counselling were more likely to return for family planning services than clients of untrained nurses, (Marquez and Kean 2012).

The key principles for cultivating good client-provider interaction and effective family planning counselling includes; show every client respect, and help each client feel at ease, ensure auditory and visual privacy and confidentiality, encourage the client to explain needs, express concerns, and ask questions, tailor the interaction to the client's needs, circumstances, and concerns, be alert to related needs such as protection from STIs/HIV, protection from gender-based violence, and support for condom use, listen carefully. Listening is as important as giving correct information, show empathy for the client's needs, remain nonjudgmental about values, behaviours, and decisions that differ from your own, remain patient with the client, and express interest, give just key information and instructions, avoid information overload, use words the client knows, demonstrate comfort in addressing sexual and gender issues, respect and support the client's informed and voluntary decisions, use and provide memory aids.

Furthermore, certain processes that help clients and providers work together to identify the most appropriate client choices, certain information on family planning methods is now considered essential to aid that decision making.

2.3.1.1Effectiveness:

Methods' effectiveness should be explained in easily understood terms. Providers must emphasize that client-controlled methods (such as oral contraceptives, barrier methods,

natural family planning, and the lactational amenorrhea method) can effectively prevent pregnancy only if correctly and consistently used, unlike long-term and permanent methods (sterilization, implants, and Intra Uterine Devices (IUDs), which are close to 100 percent effective when properly administered by the provider. Counselling can help each client weigh the trade-offs between effectiveness and other features of contraceptive methods.

2.3.1.2 Side effects:

Clients need information about common side effects and how to deal with or outlast them. Providers should invite clients to return if they cannot tolerate the side effects, and should reassure clients that they can change methods if dissatisfied. Side effects and perceived health problems are the major reasons clients give for discontinuing contraceptive use; fear of these effects is also a major reason for not adopting certain methods in the first place. A study in Niger and the Gambia found that women who received inadequate counselling about side effects were significantly more likely to stop using contraceptives, while those who were fully counselled on side effects were likely to continue using contraceptives either with the same method or with a different, more acceptable method, (Dehlendorf, Krajewski and Borrero, 2014).

2.3.1.3 Advantages and disadvantages:

Providers and clients should discuss other important features of the method, often called “advantages and disadvantages.” Such perceptions vary widely among clients. Some women may want the highly effective, continual protection of an IUD or an implant, while others may feel uncomfortable about a foreign object in their body or may want more control over their method.

2.3.1.4 Correct use:

Clients do better with brief, well-organized, clear information on how to use their selected method and, if needed to correct misperceptions, a basic explanation of how the method works (for example, some clients think that oral contraceptives need be taken only when intercourse occurs). Clients may need to develop strategies for using contraceptive methods consistently and correctly, and to receive advice on what to do if a method fails or is used incorrectly (such as if pills are skipped). Providers should respectfully request that clients repeat the instructions to be sure that the directions are well understood.

2.3.1.5 Follow-up and complications:

Clients need advice on when to return for their next injection, resupply, or follow-up. Clients should be advised about the signs of rare complications and encouraged to seek immediate help should those side effects occur. Follow-up sessions are a good time to reinforce correct and consistent use of client-controlled methods and to determine whether side effects need management. In addition to having scheduled return visits, clients need to know that they are welcome to return to the clinic any time that they have concerns (Murphy, 2007).

Building trust is a related concept to be considered by family planning providers when establishing an interpersonal relationship with their patients, the importance of working to ensure they are perceived of as trustworthy should not be overlooked. Patients commonly have concerns and misconceptions about the safety of contraceptive methods and the potential for side effects, and several studies indicate that women may have doubts about their providers' willingness to reveal potential negative aspects of contraceptive use, (Halpern, Lopez, Grimes and Gallo, 2011). This lack of trust may negatively impact women's willingness to use contraception. While one approach to this issue is a full discussion of side effects, on a relational level providers can work to

enhance respectful communication, including a demonstrated interest in understanding patient concerns, (Dehlendorf, Krajewski and Borrero, 2014).

Studies find that women are more likely to seek out and continue using family planning services if they receive respectful and friendly treatment (Vera 1993; Ndhlovu 1995; Kenny 1995, as cited in Stein 1998; Williams *et al*. 2000 as cited in Creel, Sass and Yinger, 2015). In many societies, courtesy is a sign that the client is regarded as the provider's equal. Research shows that the provider's tone, manner, and modes of speech are important to clients (Whittaker 1996; Schuler and Hossain 1998; Matamala 1998 as cited in Creel, Sass and Yinger, 2015). In one study in Zaire, most women who were asked about the two best qualities for a nurse first mentioned qualities related to communication style, such as respect and attentiveness, and second listed technical qualities (Haddad and Fournier 1995 as cited in Creel, Sass and Yinger, 2015).

2.3.2 Informed and voluntary decision-making process

Family planning decision-making often begins at home, as couples gather information from friends, the media and previous health care encounters and discuss the issue together. Indeed, so many aspects of the decision-making process already have taken place before the client arrives for a family planning consultation that some researchers have questioned whether clients actually make contraceptive decisions during family planning counselling sessions, (Dehlendorf, Krajewski and Borrero, 2014). Instead, clients may come for services already having chosen a method (Green clients). The NDHS (2018), ascertained that among currently married women who are users of family planning in Nigeria, 66% reported that they decided jointly with their husband to use family planning, whereas 23% said that they made their own decision.

Quality counselling 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, (ACQUIRE Project 2008). The counselling process should reflect the principle of informed choice and involve decisions that clients make for themselves. Respecting autonomy in decision-making requires that any counselling, advice or information that is provided by health workers or other support staff should be non-directive, enabling individuals to make decisions that are best for themselves. People should be able to choose their preferred method of contraception, taking into consideration their own health and social needs(ACQUIRE Project 2008).

In addition, it has proven remarkably difficult to define what "informed" really means for family planning clients, and it is unclear how much and what kinds of information facilitate contraceptive choice.For example, providers may be trained to tell clients about every available method, regardless of its relevance, in order to give clients the broadest range of choices, both for now and for the future. Yet, informing clients about a great number of methods may not necessarily be in their best interest: Research conducted in Nigeria found that the greater the number of methods mentioned during a counselling session, the less likely the client was to return for another visit, (Dehlendorf, Krajewski and Borrero, 2014). Likewise, a study of six countries (including Kenya) showed that the amount of method-related information that clients received during counselling was positively associated with the likelihood of method discontinuation.

Optimizing decision making is a key component of relational communication on how providers and patients can and should interact when choosing the contraceptive method

the patient will use. There is a tension between prioritizing patient autonomy in the choice of a method and the desire to encourage women to use highly effective methods. On one side, the recognition of contraceptive choice as a highly personal decision that relates to intimate issues such as sexuality and future fertility desires is the most important consideration. From this perspective, (Halpern, Lopez, Grimes and Gallo, 2011) providers should focus on being objective and nonjudgmental, providing only information and not participating in the selection of the method itself, so as to ensure that women are not inappropriately influenced.

2.3.3 Knowledge on contraceptive methods

The purpose of family planning counselling is to help the client make informed choices about reproductive health and family planning issues. Informed choice, which should-among other topics-cover knowledge transfer about the mode of action of the chosen method, has been shown to improve efficiency and compliance to contraceptive method use, (Topsever*et.al*, 2006). Thus, correct knowledge about the mode of action of the method chosen, can be considered an efficacy outcome for family planning counselling. Studies have also found that provision of information about side effects specifically is associated with improved outcomes and improves compliance, (Dehlendorf, Krajewski and Borrero, 2014).

NDHS (2018) reported that three quarters (74%) of all women currently using modern contraceptive methods in Nigeria were informed about side effects associated with the method they used, and 68% were informed about what to do if they experienced side effects. Higher percentages (83%) were informed about other available methods. Overall, 65% of women currently using modern contraceptives were informed about the method information index (side effects of the method, what to do if they experience

side effects, and other available methods) at the time they started their last episode of use.

A study in Kenya indicates that women were not satisfied with the information provided; they wanted to hear about a larger number of methods so that they could make an informed choice (Ndhlovu, 1995 as cited in Creel, Sass and Yinger, 2015). Over 40 percent of the women in one Indonesian study wanted more information on side effects, and over 26 percent wanted to know more about how contraceptives work (Irwanto, 2007).

A study conducted in Brazil by Ferreira, Souza, Lima and Braga, (2010), concluded that Knowledge on contraceptive methods was found to be worldwide. All women in the study reported knowing about condoms, oral contraceptives and injectables, while 92.6% had knowledge on the intrauterine device (IUD), 90.7% on sterilization and 90% on coitus interruptus. Vasectomy was mentioned by 88.7% of them, while over 70% reported the knowledge of emergency contraception. Only 30.7% of the interviewed women mentioned about the diaphragm.

2.3.4 Strategies to Improve Provider's Quality of Contraceptive Counseling

Effective communication is essential to help family planning clients make informed decisions when they are faced with choosing between multiple contraceptive methods. However, family planning clients are frequently passive in communicating their needs and preferences (Kim, 2001 as cited in Halpern, Lopez, Grimes and Gallo, 2011).

Public health professionals, reproductive health providers and major health organisations such as World Health Organization (WHO) have introduced counselling interventions as a key element in family planning care, to improve contraceptive use

and compliance in order to prevent unintended pregnancy (Landry 2008; WHO 2004 as cited in Halpern, Lopez, Grimes and Gallo, 2011).

Some approaches to counselling might be more effective than others. For instance, structured counselling has been designed to prevent unintended pregnancy. Any counselling consisting of audio and visual materials with standardised information is known as structured counselling, (Langston 2010 as cited in Halpern, Lopez, Grimes and Gallo, 2011). Using a structure provides a framework for the counselling process, allowing the client to visualise and hear the information in order to progress through the stages towards an informed choice of a medically appropriate contraceptive that truly meets their needs. Structured counselling is standardised in that clients receive tailored and well-structured information on the effectiveness, use and possible side effects of contraceptive method(s). Another component of structured counselling is the opportunity for participants to ask questions and receive correct answers. Different types of structured counselling interventions have been introduced in recent years to improve the quality of care in counselling. For example, the Population Council introduced the 'Balanced Counselling Strategy (BCS)' (Martin 2003 as cited in Halpern, Lopez, Grimes and Gallo, 2011).

2.3.4.1Balanced Counselling Strategy:

A balanced counselling strategy combines an algorithm of family planning counselling with a set of job aids: cards and pamphlets on methods available to improve the quality of counselling. When providers have used both the algorithm and the job aids, the quality of counselling has improved (León 2003). Three job aids used in the BCS are: A poster describing the new counselling model, with step by step guidance for the provider, a set of 11 palm-sized cards, one per contraceptive method offered and a set of 11 four-page pamphlets, describing each method. The BCS intervention has

improved worker performance by minimising reliance on memory and promoting compliance with standards (León 2003). The BCS was developed and tested in Kenya, Bangladesh and South Africa and has been integrated into the national family planning programmes of many countries (León 2008).

2.3.4.2 Decision-Making Tool (DMT):

Another structured counselling intervention developed by the WHO is called the 'Decision-Making Tool' (DMT) for family planning clients and providers (Johnson 2010 as cited in Halpern, Lopez, Grimes and Gallo, 2011). The DMT is designed to enhance the quality of care by improving the counselling process through better client-provider interactions, provision of accurate information and by increasing informed choice. The DMT is essentially a generic, two-sided flip chart that providers use in their counselling discussions with family planning clients. Studies have shown that the DMT could improve health communication between provider and client, and that it is useful both as a job aid for providers and as a decision aid for clients.

2.3.4.3. Client-centered:

Client-centered services not only meet technical standards of quality, but also satisfy clients' desire for method choice and availability, respectful and friendly treatment, privacy and confidentiality, professional competence, information and counselling, and convenient hours and waiting times.

Having shared goals for improving quality of care will ultimately lead to greater use and sustainability of health services, and improved health outcomes for women, and couples, (Creel, Sass and Yinger, 2015).

2.3.4.4. Provision of Educational Materials:

The quality of family planning counselling is an important component in increasing contraceptive uptake; interventions such as specialist contraceptive counselling can increase uptake of long term contraceptive methods (Davie 1996 in Arrowsmith, Aicken, Saxena and Majeed, 2012). Interventions could be client-or provider-focused and may include provision of educational materials or programmes, peer or multi-component counselling, medical interventions to increase acceptability, provider education programmes and checklist tools.With the help of leaflets, counselling becomes easier and quicker. Leaflets should be made available not just in healthcare providers' offices, but also in colleges and family planning centers, (Ferreira, Boa-viagem and Souza, 2015).

2.3.4.5. Messaging:

David and Lucile foundation, (2015), conducted a research on women during their postnatal care visit; clients who choose to start a contraceptive method can sign up for a six-week mobile outreach service. Those who enrol are sent customized text messages that provide; Information on method-specific side effects and Reminders for follow-up appointments. Text messages also have a built-in call-back function; women can reply to the text message and request a phone counselling session with a nurse. Preliminary findings from the text messaging pilot show an increase in perceived quality of family planning services. Clients who received text messages were more likely to have heard all key family planning counselling messages (such as how to use the method, what to do if problems arise, and the availability of alternative methods) than those who only received in-person family planning counselling. They were also more likely to rate facilities highly on six measures of quality of care (including privacy of care and availability of opportunities to ask questions), and were less likely to report having unaddressed concerns about family planning, (Ferreira, Boa-viagem and Souza, 2015).

The designers of structured counselling believe that using audio-visual components and standard information, giving clients personalised and tailored information and helping them clarify their values regarding contraceptive benefits and risks will ultimately help them to choose a method that suits their circumstances and preferences. For counsellors, the structured process could help them to provide more complete information, improve their performance by reducing guesswork and promote compliance with standards. Reproductive health providers in developing countries frequently receive limited training and supervision. Structured counselling may therefore be useful in low- and middle-income countries where access to education and hence literacy remains limited for many women, (Halpern, Lopez, Grimes and Gallo, 2011).

2.4Contraceptives Method Mix

The distribution of contraceptive use across methods provides an evidenced that women or couples have some degree of freedom of choice to select method that suits them best and change methods as their circumstances and needs change(Bertrand, Rice, Sullivan, and Shelton, 2010). However, there is often concern at the international level when a single method predominates in a country, suggesting some systematic limitation of contraceptive choice, belief and norms, religious factors, value placed on modesty, insufficiency of alternative methods or provider bias(Bertrand, et.al, 2010).

Family planning clients are offered a range of contraceptive methods. “Method mix” refers to the distribution of contraceptive methods used by a population (i.e., the percentage that uses each method), (Bertrand, et.al, 2010). Method mix provides information on the relative level of use of different contraceptive methods. There is no “optimal” or “ideal” method mix recognized as such by the International Reproductive Health community, (Bertrand, et.al, 2010). Indeed, conventional wisdom holds that

there is no single “best” contraceptive; rather, couples are encouraged to adopt the method with the most benefits and the fewest drawbacks or side effects, based on their individual perceptions. Moreover, the popularity of a method can be traced to a number of factors; such as length of effectiveness, discretion and knowledge of a method.

Contraceptive preferences and the promotion of different methods vary by region and country; therefore, so does the contraceptive method mix, or the share of use represented by each method, (Seiber, Bertrand and Sullivan, 2007).On a global basis, the most widely used contraceptive methods are female sterilization, the pill, and the IUD (Robey et al. 1992; Ross et al., 1999 as cited in Bertrand, Rice, Sullivan, Shelton, 2010). However, the method preferences of a given country may deviate from this. For example, sterilization is not widely accepted in many Muslim countries, even those considered success stories for family planning, such as Indonesia and Morocco (Bertrand, et.al. 2010). By contrast, it is a vastly popular method in many Latin American countries where the small child norm is widely embraced and women marrying at a fairly young age seek a long-term solution to pregnancy prevention. As for reversible methods, the pill or the Intra Uterine Contraceptive Device (IUCD) often occupy the top position, with many countries showing strong preference for one over the other.

According to Selber, Bertrand and Sullivan(2007) reported that one-third of developing countries have a much skewed method mix, in which a single method accounts for more than half of contraceptive use. They stated that female sterilization is the most widely employed method in developing countries, followed by the IUD, the pill and injectables. However, female sterilization is little used in the Near East, North Africa or Sub-Saharan Africa (Selber, Bertrand and Sullivan, 2007). The study further revealed a remarkable increase in injectable use in Sub-Saharan Africa and in lower-income Latin

American countries. In Nigeria, contraceptive method mix as reported by (Nigerian F2020 core indicator`s fact sheet, 2018) was as follows; injectable 22.3%, pills 17.0%, condom 40%, IUD 7.1%, sterilization 2.7%, LAM 2.7%, and other modern methods is 5.4%. The injectable, a highly effective and reversible method that meets the needs of women who want to space rather than limit their births, is the leading method in a number of Sub-Saharan African countries. The most commonly used modern methods of contraception among currently married women are injectables and implants (3% each), while the most common modern method used by sexually active unmarried women is the male condom (19%) (NDHS, 2018). The rapid increase in injectable use is largely attributable to its widespread accessibility. Furthermore, women can use this method without others knowing about it and the quality of counselling service provided by the family planning providers is not inclusive of all contraceptive choices, (Gebremariam and Addissie, 2014).

Contraceptive methods used for family planning can be grouped into two categories programmatically. These are long-acting and permanent methods (intrauterine devices, implants, and sterilization) and short-term methods (pills, condoms, spermicides, injectables, other modern methods, and all traditional methods). Long-acting and permanent methods are usually used to limit childbearing, whereas short-term methods are better suited for women who want to delay but not forfeit having a child, (Gebremariam and Addissie, 2014).

On average, a Nigerian woman or man aged 15-49 knows about 5 out of the above mentioned methods of contraceptives. On top of this, the most common methods cited were those that carry the highest risks of pregnancy. The most common method women cited was the pill (71%) which has a failure rate of 9% and can lead to nine unintended pregnancies per one hundred women a year. For men, the most common method cited

was the male condom (91%), which has a failure rate of 18%. This can lead to 18 unintended pregnancies per one hundred women in a year(Nigeria family planning blue print, 2014).

Among the least known methods by both men and women in Nigeria was the long acting reversible implants method which can last between three to five years for women who use it(Nigeria family planning blue print, 2014). Implants have a 0.05% failure rate. However, only 17.9% men and 24.7% women knew about it, (Nigeria family planning blue print, 2014).

Depo-Provera, a three-month injectable, was relatively under-utilized until the early 1990's, when approval by the food and drug administration (FDA) created a climate for greater acceptance worldwide, (Bongaarts and Kantorova, 2002). Despite rising popularity, it has yet to gain the extent of acceptance of the three leading methods (sterilization, the pill, and the IUD).

Contraceptive prevalence and method mix are influenced by a range of factors. According to Sullivan et al (2006) as cited in (Mackenzie, Drahota, Pallikadavath, Stones and Dean, 2013) these factors are:

2.4.1Policies and programmes: Government promotion of certain methods at the expense of others, regulatory barriers, capacity and motivation to provide range of methods

2.4.2. Provider bias: provider preference for specific methods.

2.4.3. History: length of time since introduction of each method in a country.

2.4.4. Property of methods themselves: ease of distribution, high programme cost, side-effects, effectiveness.

2.4.5. Client characteristics: knowledge of alternative methods, desire for limiting vs. spacing, religious beliefs, personal preferences, age and life stage.

Furthermore, despite the availability and provision of all contraceptive methods, only four methods were accepted by the women after counselling. The most popular methods were oral contraceptives and injectables, followed by condom and IUD. A high acceptance of injectables may be due to a more fool-proof method and is likely to be easier to use. The most known methods were also the most chosen ones with the exception of the IUD, despite being the fourth most known method (92.6%) it was chosen by only one woman, (Ferreira, Souza, Lima and Braga, 2010).Lack of knowledge, misperceptions, and exaggerated concerns about the safety of contraceptive methods are major barriers to contraceptive use.

In a study to assess family planning use in Bauchi and Sokoto States by (United States Agency for International Development (USAID), 2015) revealed that, most of the included facilities under study, injectables were reported as the most preferred method by family planning clients. This was followed by implants and then oral contraceptives. A respondent in a Primary Health Care (PHC) facility in Bauchi stated that "they use two methods most: injectables and implants, but injectables are used more," while another one mentioned that "mostly they like Noristerat injection, hardly IUD but Implanon and Jadelle are now common." In other areas, implants were the preferred contraceptive by the clients. A provider in a secondary health facility in Sokoto State, reported that "Implanon is the most common," while another one from the same facility confirmed that "they come for Implanon more than injectables, out of five you can have three for Implanon while one or two will go for injectables." Another provider from a rural PHC stated that "before we started using Implanon and Jadelle, injection was the most preferred but now the majority are on Implanon then injectables (USAID, 2015).

Studies conducted from 1999 to 2008 in northern Nigeria submitted that contraceptive prevalence was 31.6% among women attending antenatal care. The most common method were injectables (noristerate and depo-provera) used by 68% of the client, oral contraceptive accounting for 10.4%, male condom 2.8%, female sterilization 3.4%, IUCD 16.6%, followed by implant contributing 2% only. The study further revealed that oral contraceptive, male condom, IUCD and implant sharply dropped during the subsequent 2 years of the study, while injectable contraceptives contribution to the method mix increased from 52.4% at the beginning of the study to 54.4% and it's used increased over time through 63.9% to 72.1% during the year 2007 to 2008 due mainly to subsidy provided for the method and ease of administration. Female sterilization despite been popular worldwide, it contributed the least quota (3.5%) to the contraceptive mix in the study, reasons given were due to cost, socio-cultural belief and premium given to childbirth in our environment, (Muhammad and Maimuna, 2014).

2.5 Clients' Satisfaction

Clients' satisfaction is the key indicator that can reflect the health service quality at any level of health care. Assessment of clients' satisfaction provide an opportunity to involve clients in process of assessing program from users' perspective and is recognized as a component of quality of care, (Aminu, 2015). Therefore, assessing clients' satisfaction helps to evaluate quality of service.

One critical determinant of adoption and continuation of contraceptives is overall client satisfaction with family planning services. Therefore, provision of good-quality contraceptive services is vital to reducing unmet need for family planning. This includes broadening method choice and ensuring that any health concerns related to family planning are adequately addressed, (Hutchinson, Do & Agha, 2011). Research conducted in Nigeria found that the greater the number of methods mentioned during a

counselling session, the less likely the client was to return for another visit, (Dehlendorf, Krajewski and Borrero, 2014). Likewise, a study of six countries (including Kenya) showed that the amount of method-related information that clients received during counselling was positively associated with the likelihood of method discontinuation and lack of satisfaction(Hutchinson & Agha, 2011).

In a study of determinant of clients' satisfaction with FP services in government health facilities of Sokoto Northern Nigeria, revealed that significant proportion of the respondents expressed satisfaction on family planning services provided, while only 15% were dissatisfied with the FP service delivery, (Aminu, 2015).

Method related reasons like health concerns, fear of side effects, and lack of access/too far, too much costs and health care provider bias accounted for 32.4% of non-utilizations of family planning services. In a similar study carried out by (Eze and Hope, 2014) in Adankolo town of kogi state in Nigeria, women have seen the need for birth control but cultural, religious and gender factors still obstruct full implementation even among the literates.

A study in Kenya by Hutchinson & Agha, (2011), revealed that clients were satisfied with FP services and had no problems with all of the following: waiting time 93.1%, ability to discuss concerns with provider 97.2%, amount of explanation given 92.0%, quality of examination and treatment provided 96.2%, visual privacy during examination 97.1%, auditory privacy during examination 96.7%, availability of the methods at facility 97.6%, hours of service provision 96.0%, cleanliness of facility 99.5% and how the staff deals with the client 100%. The same study also reported that around 95.8% of all the clients mentioned that they would return to the health facility for future services. In addition, around 97% of the clients mentioned that they would suggest others to visit the health facility. These study findings highlight some of the

changes that are needed to increase client satisfaction at public sector family planning services in Kenya in order to achieve maximum satisfaction. The large discrepancy in waiting time between public and private sector facilities and the perception of waiting time as a major problem emphasizes the need to consider mechanisms to lower the client load on public facilities in Kenya(Hutchinson & Agha, 2011).

Approximately nine out of ten clients felt they had adequate privacy during their visit, believed in the confidentiality of their services, felt they received the right amount of information, and were satisfied with services overall (Ayona, 2017). Fewer clients—only 3 out of 4—were satisfied with the amount of time they had to wait for services.

In a study conducted at Wojihospital in Ethiopia by (Ayona, 2017) affirmed that clients'satisfaction on utilization of FP service delivery is low with service providers restricting information on long term contraceptive, limiting methods to hormonal methods, injectable and oral contraceptive pill, prolong waiting time and insufficient information on method of choice.

It was noticed that, none of the nurses wear gloves in the family planning room during physical examination procedure, (Nasr and Hassan, 2016). However, about three-quarters of nurses performed infection prevention and maintaining sterile technique in family planning procedure rooms. Findings of the study further showed that, the great majority (99.59%) of the clients were satisfied about all items related to the clinic especially in cleanliness of the examination room, availability of the methods at the clinic, provision of privacy during health education by the provider and cost of the family planning methods. The cost for the family planning methods is a vital point for women as the great majority of them (86.25%) were housewife and more than half of them (54.16%) had insufficient income, (Nasr and Hassan, 2016).

2.5.1 Factors that Influence Clients' Satisfaction with Family Planning Services

2.5.1.1Method Choice and Availability: Clients want a variety of services. Providing a wide range of contraceptive methods can help clients find those that match their health circumstances, lifestyle, and preferences, (Ross et al. 2002 as cited in Creel, Sass and Yinger, 2015). In an assessment of nine countries, the percentage of women who said that they would rather be using a different method ranged from 11 percent (Mauritius) to 48 percent (Costa Rica). Respondents cited several reasons, including the cost of their preferred methods, difficulty obtaining their current methods, medical ineligibility for other methods, and family disapproval of certain methods, (U.S. Centers for Disease Control and Prevention Reproductive Health Surveys, 1991-1999, as cited in Creel, Sass and Yinger, 2015). Supply shortages can lead to dissatisfaction; as a result, some clients may discontinue using family planning altogether. Provider bias, which occurs when service providers believe that they are in a better position to choose the most appropriate method for the client, or are biased toward certain methods, may preclude women from using a method appropriate to their circumstances and needs.

One woman in Kenya explained, "I asked them to give me the injectable. They told me that the pill was okay with me and I couldn't receive the injectable with only two children. I decided to stop and have never gone back" (Ndhlovu 1995as cited in Creel, Sass and Yinger, 2015). If clients do not receive their preferred method or service, or are turned away without receiving satisfactory diagnoses, they may stop seeking care. Clients may also say that they are satisfied with care because they want to please the interviewer, worry that care may be withheld in the future, or have some cultural or other reason to fear complaining (Creel, Sass and Yinger, 2015).

2.5.1.2 Respectful and Friendly Treatment: Studies find that women are more likely to seekout and continue using family planning servicesif they receive respectful and

friendly treatment, (Vera 1993; Ndhlovu 1995; Kenny 1995, as citedin Stein 1998; Williams et al. 2000 as cited in Creel, Sass and Yinger, 2015). In manysocieties, courtesy is a sign that the client isregarded as the provider's equal. Researchshows that the provider's tone, manner, and modes of speech are important to clients, (Whittaker 1996; Schuler and Hossain 1998; Matamala 1998 as cited in Creel, Sass and Yinger, 2015). In one study in Zaire, most women who were asked about the two best qualities for a nurse first mentioned qualities related to communication style, such as respect and attentiveness, and second listed technical qualities, (Haddad and Fournier 1995 as cited in Creel, Sass and Yinger, 2015).

2.5.1.3Privacy and Confidentiality: Clients feel more comfortable if providersrespect their privacy during counseling sessions,examinations, and procedures. In a qualitativestudy in Chile, between 30 percent and50 percent of female patients reported a lack ofprivacy during gynecological examinations.One woman commented, "The exam and theclean-up afterwards shouldn't be done so publicly, because there are men moving around in the halls and you feel really embarrassed. There should be a curtain or a door. I don't want people to see my body", (Matamala 1998: 15 as cited in Creel, Sass and Yinger, 2015). Clients, particularly those who obtain services in secret—report higher satisfaction with providers who keep their needs and personal information confidential, (Ndhlovu 1995: as cited in Creel, Sass and Yinger, 2015). Lack of privacy can violate women's sense of modesty and make it more difficult for them to participate actively in selecting a family planning method. In a few places, obtaining and using contraceptives can be a difficult and risky decision that can lead to abandonment, violence, ostracism, or divorce. In those situations, women need assurance of absolute confidentiality. **:** Privacy during client consultations is inadequate

at many health facilities. Inconvenient times of services, long waiting times, and providers of the opposite sex also reduce service satisfaction for clients.

2.5.1.4 Competent Service Providers: Clients say that they value service providers'technical competence, as well as privacy andconfidentiality. Clients' definitions of competencedo not always coincide with technical definitions of quality. In Zambia, clients basedtheir judgment on how thoroughly they wereexamined, (Ndhlovu 1995: as cited in Creel, Sass and Yinger, 2015). In Chile, all butone respondent mentioned the facility's cleanlinessas a sign of the quality of the clinic'sservices, (Vera 1993 as cited in Upadhyay 2011). Ultimately, clients' judgetechnical competence by whether their needsare met or their problems are resolved.

2.5.1.5 Convenient Schedules and Waiting Times: Long waiting times and inconvenient clinichours can prevent clients from obtainingthe services they need. In both Malawi andSenegal, clients identified long waiting timesas a concern. One client said, "The wait is abig problem. I'll sometimes skip my appointmentif I think about the hours I'll have tospend at the center", (Ndhlovu 1995: as cited in Creel, Sass and Yinger, 2015).Some clinics do not post their hours ofservice, or do not serve clients during certainhours when they are supposed to be open. Astudy in Kenya found that although clinicswere officially open from 8 a.m. to 5 p.m.,providers discouraged clients from coming inthe afternoons and often did not provide servicesto women who were only able to attend inthe afternoon, (Population Council, 2008). Rigid and relatively short clinic opening times for client consultation (generally Monday to Friday from 8 am until around 1pm) reduce service availability contribute to long waiting times when the clinic is open. The availability of contraception is further reduced at clinics where contraceptive services are not integrated into primary health care services.

2.5.1.6 Affordable Services: Clients are generally more likely to use low-costservices. In Kenya, clients said that low costsand proximity of services were the two mostimportant factors that attracted them to services, (Ndhlovu 1995: as cited in Creel, Sass and Yinger, 2015). Clients may be willing to accept highercosts if they believe that services are of highquality.

2.5.1.7Easy access to services: Inequalities in access to health services still exist in developing countries. This applies particularly to disadvantaged communities such as people living in rural areas and peri-urban informal settlements (Creel, Sass and Yinger, 2015).

2.5.1.8 Provider bias: which occurs when service providers believe that they are in a better position to choose the most appropriate method for the client, or are biased toward certain methods, may preclude women from using a method appropriate to their circumstances and needs. One woman in Kenya explained, "I asked them to give me the injectable. They told me that the pill was okay with me and I couldn't receive the injectable with only two children. I decided to stop and have never gone back", (Ndhlovu 1995: as cited in Creel, Sass and Yinger, 2015). If clients do not receive their preferred method or service, or are turned away without receiving satisfactory diagnoses, they may stop seeking care, (Cotten*et al*. 1992, as cited in Koenig et al. 1997; Parian*i et al.* 1991 as cited in Creel, Sass and Yinger, 2015).

2.6. Theoretical Framework

The Avedis Donabedian model of quality is often considered the central paradigm for quality in international family planning. The Donabedian model assumes the existence of three essential factors in assessing quality-structure, process and outcome- and possibly a causal relationship between them. For Donabedian (2005),structure refers to places where medical care takes place and the instrumentalities of each product these

include: features of the system, the infrastructure, supplies, the service providers and patient. Process refers to the set of activities that takes place in the system, on one had between professionals and on the other, between professionals and the patients.Outcomes are the consequences for the well-being of the individuals and society (Donabedian, 1988).

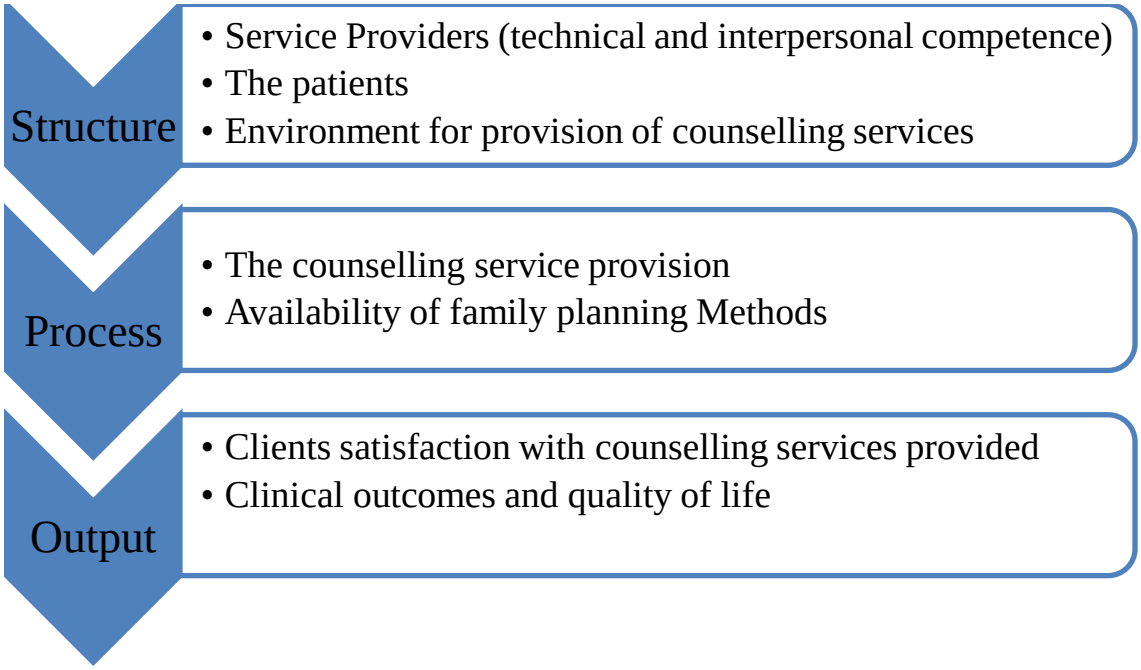

Fig. 2.1Donabedian Quality model(1980)

Application of Donabedian model ofQuality in Family Planning Service Delivery

Structure

- **Formally Trained/Certified Service Providers**

Provider Competence: Provider competence refers to the technical competence of the service provider. A competent provider is one who demonstrates adequate technical competence and adherence to medical guidelines and protocols. Failure to observe safe clinical standards may not only result in harmful health outcomes but could also generate negative rumours about family planning programs or methods. Observations

of client-provider interactions are frequently employed to determine whether providers engage in such basic procedures as adequate record-keeping and hand-washing prior to physical exams. In addition to inadvertent violations of medical guidelines, examples exist of providers imposing excessively restrictive medical criteria that effectively block access to services for women who would like to avoid unintended pregnancy. Such behaviour on the part of the service provider leads to what is commonly referred to as 'medical barriers' to contraceptive services (Bertrand et al., 1995). Providers may restrict access for any number of reasons, including the client's pregnancy status, misinformation such as use of out-dated eligibility criteria, and personal bias on the part of the provider (Greene &Stanback, 2011; Bertrand et al., 1995 as cited in Tumlinson, 2014). Quality assessment is necessary to determine existing disparities between standards of technical competence and actual practice in the field, (Bruce, 1990 as cited in Tumlinson, 2014).

Process

- **Quality of Counselling**

Information Given to Clients: Providing information to clients means that clients receive information from their service provider on a range of methods, including the advantages and disadvantages of each method and instructions for using the client's method of choice (Jain, 1989 as cited in Tumlinson, 2014). The provision of this information allows clients to understand they can choose from a variety of methods, each with different attributes. In addition, clients can be prepared to anticipate the possibility of experiencing side effects with the use of certain hormonal methods, the presence of which may affect daily activities. As Bruce (1990 as cited in Tumlinson, 2014) points out, the client is selecting a method that must fit into her daily life,

including social activities and intimate sexual experiences. Unpredictable menstrual patterns, for example, may impact religious practices, work routines, and sexual experiences and it is important for women to be prepared for this possibility in advance (Bruce, 1990 as cited in Tumlinson, 2014). By ensuring that the client is informed and knowledgeable about potential side effects, the provider is, in effect, helping the client manage their expectations of their contraceptive experience.

- **Interpersonal Relations**

Interpersonal relations can be viewed as the personal or human aspect of service provision. A good interpersonal relationship is one in which a 'positive and productive' interaction takes place between the client and provider from the client's perspective, (Bruce, 1990as cited in Tumlinson, 2014). Interpersonal relations between providers and clients may influence client confidence in and satisfaction with their chosen method as well as increase the likelihood of a return visit, (Bruce, 1990as cited in Tumlinson, 2014). Bruce (1990 as cited in Tumlinson, 2014) suggests that good interpersonal relations require understanding and respect on the part of the provider, including bi-directional communication and the opportunity for the client to ask questions rather than merely receive authoritative lectures (Bruce, 1990 as cited in Tumlinson, 2014). This may also include offering the client reassurance, caring, and sympathy when needed and observance of the client's modesty wherever appropriate. Interventions to improve client-provider interactions may include analysis of providers' case-loads or increased managerial support for improved interpersonal performance (Bruce, 1990; Jain, 1989 as cited in Tumlinson, 2014).

- **Method mix**

I. **Choice of Methods:** Having a choice of methods means that a satisfactory selection of methods, in terms of both number and type, is available on a reliable basis. Choice of methods is determined by the physical availability of multiple methods for client to willingly select her choice. Choice is important for multiple reasons. Women and their partners have different reproductive needs at different stages of their lives, depending on their age, parity, type of relationship, and lactation status (Jain et al., 1992as cited in Tumlinson, 2014).

II. **Continuity and Follow-Up:** This element of quality ensures that follow-up mechanisms are in place, such as scheduling of future appointments or home visits, to encourage contraceptive continuity. Assisting clients with resupply may result in greater rates of contraceptive continuation, an important component of the overall prevalence rate (Bruce, 1990 as cited in Tumlinson, 2014).

Output

- **Client satisfaction with services provided**

For clients to achieve satisfaction with the counselling services, these three factors (structure, process and outcomes) must be correlated in the same direction. The structure in which counselling services is given should be positive in terms of time, privacy, spacious, infection prevention and control;this favourable situation should extend to processes and outcomes. If, on the other hand, the positive perception extends to all three factors, then the client's needs are said to be satisfactorily.

2.8 Nurses role in family planning counselling

The health care provider's role includes provision of information, facilitating the identification of patient preferences, ensuring that preferences are not based on

misinformation, helping patients to think about how their preferences relate to the available options, and coming to a mutually acceptable decision. Other roles include educating clients in various methods available, their effectiveness and their side effect.Helpclientexplore their feelings regarding birth control.Create open relaxed atmosphere allowing clients to express their concerns and feelings about birth control.Thorough explanation of how methods work and instructing client in possible complications and side effects

Skills and characteristics of a counsellor:the most important characteristics of a counsellor are: respect the dignity of others, respect the client's concerns and ideas, be non-judgmental and open, show that you are being an active listener, be empathetic and caring and been honest and sensitive.

CHAPTER THREE

METHODOLOGY

3.0 Introduction

This chapter discusses the methods to be used in collecting data under the following sub-headings: research design, population of the study, sample and sampling procedure, data collection instrument, validation of the instrument, data collection procedure, data analysis and ethical consideration.

3.1 Research Design

A concurrent mixed method research design (qualitative and quantitative design) was adopted to assess quality of care for contraceptive counselling services in some selected public health care facilities ofZamfarastate. Mixed methods research design is a methodology for conducting research that involves collecting, analyzing and integrating quantitative and qualitative research. This approach is used when this integration provides a better understanding of the research problem. By mixing both quantitative and qualitative research methods, the researcher gain in breadth and depth of understanding and corroboration, while offsetting the weaknesses inherent to using each approach (Creswell and Plano, 2011). In this study, the qualitative component comprised of clientsexit interviews and observation of counselling sessions. The quantitative component was a descriptive study design that entailed scrutinising the FP service delivery registers/records in the selected facilities.

3.2 Study Area/ Setting

Zamfara is a state in north-western Nigeria carved out of Sokoto State on October 1, 1996 by the then regime of General SaniAbacha, with its capital inGusau. Zamfara state

occupies a total land area of 38,418 square kilometres; it is bordered in the North by Niger republic, to the South by Kaduna State. In the east it is bordered by Katsina State and to the West by Sokoto and Niger States. It has a population of 3,278,873 according to the 2006 census and made up offourteen local government areas. Zamfara State is mainly populated by Hausa and Fulani people, with a few other minor tribal groups as: Gwari, Kamuku, Kambari, Dukawa, Bussawa and Zabarma ethnic communities. Others include Igbo, Yoruba, Kanuri, Nupe and Tiv.

The state has a total of 841 health facilities broken down into tertiary hospitals(one of which belong to the Federal Government-the Federal Medical Centre Gusau), 22general/districthospitals and over 818 PHCs. Ninety eight percent of these health care facilities are public owned. The remaining 2% are private providers. All of the hospitals in the state are providing family planning services. These family planning units are manned by nurses and midwives who are trained in various contraceptive methods and occasionally medical doctors. All of the hospitals in the state are providing family planning services for eight (8) hours in a day and five days of the week.

3.3 Target Population of the Study

The population of this study constituted both new and returning clients (women of reproductive age)receiving contraceptive services within the period of data collection, state MCH coordinator and the health care service providers providing family planning service in the selected health care facilities across the 14 Local Governments Areas of Zamfara state.

3.4 Sample Size Determination

Two sample sizes were determined.

1. The seven (7) nurses who are heads of family planning units, who provides contraceptive counseling services across the 7 selected public secondary health care facilities in the state.
2. The second samples were women who are consumers of family planning services in the hospitals. The researcher interviewed 48 women across the selected hospital that willingly consented until saturation occurred and this happened when adding more participants to the study did not result in additional perspectives or information. The interview was conducted in the following order; GH Birnin Magaji 5clients, GH Shinkafi 5 clients, GH Bungudu 7 clients, ASYBSH 12 clients, GH Tsafe 8, GH T/Mafara 6 clients and GH Gummi 5 clients.

3.4.1Inclusion and Exclusion criteria

Inclusion

- ✓ Clients: women of reproductive age (15-45years) who are consumers or potential users of contraceptive methods attending family planning clinics.
- ✓ Heads of family planning clinics, including women and men (educated and qualified providers).
- ✓ State MCH coordinator

Exclusion

- ✓ Women of child bearing age that are in the facility on the day of data collection for other services not family planning.
- ✓ Women that did not consent.
- ✓ Nurses and midwives who are heads of other services in the facility.

3.5 Sampling Technique

The sample for the study was drawn from the population of the study using multi-stage sampling procedures.

Stage 1: Cluster sampling of the state into 3 existing senatorial districts; Northern, Central and western senatorial districts.

Stage 2: Clustering of 22 public health care facilities across the 3 senatorial districts in Zamfara state as below;

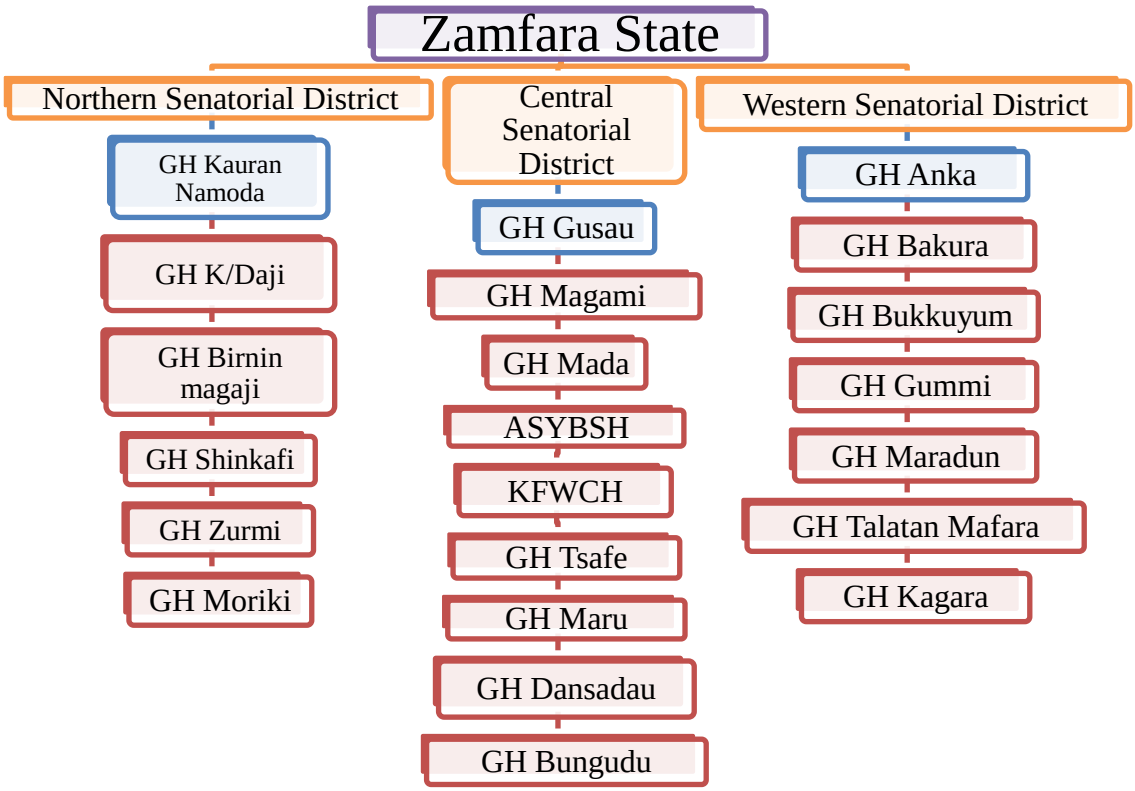

Fig. 3.1 Public health care facilities across the 3 senatorial districts

Stage 3: Proportionate allocation was utilized to select secondary health carefacilitieswith highest number of clients turn out by utilising Isaac and Micheal, (2008), 30%. A total number of 22 secondary health facilities exist in the state therefore, $30/100 \times 22 = 6.6 \approx 7$

Stage 4: Two facilities from northern zone, three from central zone and two facilities from the easternzone were randomly selected based onhighest number of facilities available in each zone as shown on the table below.

Table 3.1EnrolmentsofCounselling in each Senatorial District of Zamfara State from January 2017 to December 2017

ZONE	HEALTH FACILITY	Number of women served with FPs
Northern zone	GH BIrnin Magaji	4896
	GH Kauran namoda	2020
	GH kasuwandaji	520
	*GH Shinkafi	4897
	*GH Zurmi	1654
	GH Moriki	189
Central zone	*GH Bungudu	2784
	GH Gusau	2061
	GH Mada	659
	GH Magami	2510
	*ASYB Specialist	3171
	King Fahad WCH	733
	GH Dansaadu	299
	GH Maru	2417
	*GH Tsafe	4197
Western zone	GH Anka	1625
	GH Bakura	953
	GH Bukkuyum	1694
	*GH Gummi	3748
	GH Maradun	1890
	*GH T/mafara	3156
	GH Kagara	613
Total		48,644

*=sampled hospital selected from each zone

3.6 Data Collection Instruments

An interview guide adopted from Kim, (1995) and modified by the researcher was used to elicit response from the selectedclients' as they exit the FP Clinic. Thiswas conducted by 2 trained research assistants in the local language-Hausa. Clients' responses wereaudio recorded, the information was later transcribed and translatedto English and subsequently coded and analyzed.

The researcher observed at least two counselling sessions in all the seven selected hospital between the service providers and the clients using a checklist.The checklist contained five (5) themes with twenty nine items (29) that were rated as 'yes' or 'no'. The client's responses were subsequently coded and analysed.

Data on the number of formally trained family planning service providers in each of the selected facility was collected from the state MCH coordinator and corroborated with heads of the FP/Maternity Unit

FP delivery registers in each of the selected facilities werescrutinized to collect information on the number of clients offered contraceptive method mix for the preceding six months prior to survey/study.

3.7 Validation of the Instrument

Content and face validity of the research instrumentswas done by five jurors who are Professionals from the Ahmadu Bello University Zaria. In order to ensure face validity, the instrument for data collection was analysed with the research objectives to ensure all stated objectives were addressed.For content validity, the jurors were provided with information about the study objectives and they graded each question according to its relevance to the topic on an ordinal likert scale of four. The jurors scored each question for relevance, clarity, simplicity and ambiguity. That is, 1= for not relevant, 2= item needs some revision, 3= relevant but needs minor revision and 4 = very relevant. The

same applies to clarity, simplicity and ambiguity. The proportion of items that scored 3or 4 was calculated. A content validity index of 0.75and above was accepted. Items that scored low were reworded to ensure simplicity, clarity and reduce ambiguity. Items considered irrelevant i.e scored one (1)were removed and replaced by any relevant suggestion (s) from the jurors.Their corrections were incorporated in the final draft of the interview and observation guide.

3.8 Reliability of the Instrument

The instruments for the study was pilot tested by test and re-test method ie administering the instrument to 10 family planning client`s across the sampled health facilities and same repeated 2weeks prior to the conduct of the study to ascertain the internal consistency of the instrument. The instrument was considered reliable for this study as the Cronbach alpha was greater than 0.80.

3.9 Procedure for Data Collection

The researcher trained two research assistants for seven days on the contents of both the English and Hausa version of the research instrument for clear understanding of the contents before going to the field.

The researcher observedthe counselling sessions in all the selected public health care facilities using an observation checklist adopted from Kim (1995) and document her findings.

Two trained research assistants conductedclient exit interview(with consented clients) using interview guide which was translated into local language by experts. The interview was focused on quality of contraceptive counsellingsuch as counselling

process, IEC materials, communication, environment for counselling and clients satisfaction.

Data on the number of formally trained family planning service providers was collected from the state FP/MCH Coordinator and cross checked with the heads of each family planning units of the selected health facilities, while service delivery register of the selected health care facilities were scrutinized to collect information on the number of clients offered contraceptive method mixfor the preceding six months prior to study. Interviews were conducted at each facility for 1–5 days to offer an opportunity for full observation of contraceptive services rendered except for one health care facility that conduct family planning clinic on a particular day of the week which made the researcher and research assistants to visit the health care facility five times for five weeks.The researcher observed fourteen counselling sessions in all the facilities and with the client's permission, the research assistants audiotaped each interview session. Each tape was played back by the researcher and then translated by expertsfrom the local language into English and made a written transcript of each session. Threemonths was utilized to go round the sampled area for data collection.

3.10 Data Analysis

Data from the Client Exit Interview (CEI) was transcribed in Hausa and then translated into English by a translation expert. The data was then analyzed manually using thematic content methodology. The report from the observations of the counselling sessions were coded and also analyzed manually.The data on contraceptivemethod mix was analyzed using Excel spreadsheet 2010 and presented in a table and simple percentages.Pearson Correlation coefficient was utilized to ascertain the intercorrelation between socio-demographic characteristics of the respondents (clients) and client

satisfaction with contraceptive counselling. A p- value of 0.05 or less was considered significant.

3.11 Ethical consideration

Introductory letter was collected from the Head of Department, Nursing Sciences, Ahmadu Bello University, Zaria and was submitted to Zamfara state ministry of health. Ethical clearance was obtained from Zamfara state Ministry of Health EthicalCommittee. An official permission letter was obtained and directed to the head of nursing in the studied public health care facilities. Communication was also made with the heads of family planning units to inform them about the objectives and procedures of the study to get their cooperation and facilitation throughout its practical aspect. Written informedconsent was obtained from all participants after simple and clear explanation of the research objectives. Confidentiality was assured and maintained. All information provided wastreated with utmost confidentiality and was used only for the purpose of this study.

CHAPTER FOUR

RESULTS

4.0 Introduction

The study aimed to assess quality of contraceptive counselling in public health care facilities of Zamfara state.The data collected for this study were statistically analyzed and presented in this chapter.

Table 4.1 Socio-demographic characteristics of the respondents (Women) n=48

Variables	Frequency	%
Age		
10-14 years	7	14.6
15 -19 years	12	25
20-29 years	16	33.3
30-39 years	8	16.7
40 years and above	5	10.4
Marital Status		
Married	48	100
Level of education		
Non-formal	18	37.5
Primary	11	22.9
Secondary	10	20.8
Tertiary	9	18.8
Occupation		
Civil servant	14	29.2
Unemployed	18	37.5
House wife	16	33.3
Religion		
Islam	36	75
Christianity	10	20.8
Others	2	4.2
Parity		
1-3	12	25
4 – 6	19	39.5
7 – 10	8	16.7
11 and above	9	18.8

Table 4.1 above display the Socio-demographic characteristics of the respondents which shows that majority of them (33.3%) were aged between 20-39 years. All the respondents were married. In terms of education, 37.5% of them had secondary school certificate, while 20.8% had no formal education. When occupation is considered, most of the respondents were unemployed, followed by house wives and civil servant with 37.5%, 33.3% and 29.2% respectively. For religion, 36 (75%) practice Islam, while 10 (20.8%) practice Christianity and only few number (4.2%) practice African traditional religion. With regard to number of living children,39.5%women hadbetween 4-6 children.

Table 4.2Distribution of Trained Family Planning Service Providersper Facility (n=34)

S/No	Name of Facility	Frequency	%
1	GH Birnin Magaji	1	2.9
s2	GH Shinkafi	2	5.9
3	GH Bungudu	7	20.6
4	ASYBSH	2	5.9
5	GH Tsafe	5	14.7
6	GH Gummi	3	8.8
7	GH T/mafara	14	41.2
6	Total	34	100

Table 4.2 shows the frequency and % of trained/certified family planning service providers in the sampled public health clinics. GH Birnin magaji is the least with 2.9% followed closely by GH Shinkafi and ASYBSH with 5.9% respectively, GH T/mafara has the highest with 41.2%.

Report of Interview on Quality of Contraceptive Counseling Services as Perceived by the Respondents (n=48)

The major themes that emerged under the qualitative data includes; greetings, assessment, history, information giving/client`s provider interaction and environment

Findings from the qualitative study revealed that most of the women interviewed verbalised positiveresponses on greeting.

4.3.1 **Greetings**

This includes welcoming and receiving clients, provision of privacy and confidentiality of information. The responses are stated below;

> *"We were welcomed and greeted in a friendly and respectful manner by the service providers and seats were offered to us".*

4.3.1.1 The clients see no problem by addressing them formally.

> *"I see no problem in the way the service provider addressed me by calling my name as that is how am been called".*

4.3.1.2 Most of the client's responses were positive about provision of privacy as quoted below;

> *"Yes I don't think there is anyone that overheard our discussion today but if it was on antenatal clinic days because of too many women there is a tendency that others might hear what is been discussed, so that is why I prefer to come on a day like this where there are few women".*

4.3.1.3 Confidentiality of information shared between service provider and the clients was satisfactorily reported by the clients as most of them uttered during interview below;

> *"None of the information discussed will be leak, she isn't like that, I trust her, is a secret between us and there is no reason why she will disclose what we discussed even among her colleagues".*

4.3.2 Assessment

Most of the clients gave an explicit negativeexplanation on assessment. Assessment which includes information on utilization of any form of contraceptive before, interest in using any particular method, husband attitude towards FP, breast feeding status and need for more children in the near future. The client response during interview is stated below;

> *"No the service provider didn't ask me any question on whether I have use any method previously or my husband attitude towards family planning because I have already told her that I and my partner have already discussed at home on what method to select so she will assumed he already knew".*

4.3.2.1 On client's breastfeeding status and the need for more children in future, some client's came to the hospital with their babies, so most of them verbalized that;

> *"The service provider has already seen us with our babies, she knew that am a breastfeeding mother therefore, she didn't bother asking and I was also not asked on the need for more children in the near future".*

4.3.3 History

History taken was only focused on some aspect while other aspect were neglected as reported by majority of the client‘s. These includes history, physical examination, investigation done, explanation of investigation results and enquiry of medical conditions of the client‘s. Below are the client‘s excerpt;

> *“The only investigations carried out were urine testing to exclude pregnancy status, weighing and blood pressure measurement, but as per explanation of the result, they assume we know so it was not done, issues regarding STIs, hypertension, diabetes and other medical conditions were not discussed”.*

4.3.4 Information giving/client‘s provider interaction

Client‘s provider interaction (CPI) refers to interpersonal communications (verbal and non-verbal) between health care staff and women who seek health care services, good counselling skills, use of Information Education Communication (IEC), not been bias (non-judgemental) in selection, giving and explanation of method of choice including advantages, disadvantages and side effect was not satisfactory as most of them stated;

4.3.4.1 The communication is one way with the service provider dominating the discussion and use of IEC material was not done in most of the sampled facilities as expressed by the client‘s;

> *“The service provider just asked us what method we like and when we mentioned she gave us. Despite pasted on the wall, the IEC material where not used by the providers, they assumed we know so she didn‘t show us any it was only verbalized”*

4.3.4.2 The selection of a method by client‘s was non-judgemental with no bias shown by the providers;

"Nobody force us to select a method, it is our own choice and for the selection we have already discussed with our husband before coming to select a particular method"

4.3.4.3 Client's interviewed laments that how chosen method works, contraceptive benefits, disadvantages and side effect of selected method was not fully explained by the service providers during the counselling process, the statement of a client interviewed was below;

"The service provider didn't tell me anything in respect to how the method I selected works, she only told me when to come back for the next visit, for the side effect she only mentioned bleeding"

4.3.5 Environment

The environment for consultations and counselling includes examination room, waiting/seating space and toilet facility. Excerpt of statements by a client;

"Consultations/counselling usually take place in the nurses' station or labour room and waiting/seating space is always almost in the antenatal care unit with most of them verbalizing that we have no idea on what the toilet facility looks like because we have never visited the toilet for any call of nature",

Facility Observations Made during Family Planning Counselling

The researcher observed counselling process between the service providers and the clients which is categorised into the following themes;

- ✓ **Environment for counselling**: the environment for counselling is not well ear marked, there is no separate room for counselling process; this is carried out in the antenatal clinics or nurses' station of the labour ward with only one hospital

having a waiting space and examination room separate from the space provided for antenatal care services.

- ✓ **Establishment of rapport**: observation made during the period of data collection revealed that manner of greeting in all the public health care facilities visited was the same, with the clients greeting the health care providers first, except for one health care facility where the service provider greeted the clients before initiating group counselling, the clients are the first to initiate greetings as they arrived the hospital after which they are offered a seat to await consultations.
- ✓ **Providing information**: good interpersonal communication in exchange of information between the service provider and the client was observed in five of the health care centers, enquiry on previous use of any contraceptive method was done in four out of the seven hospitals visited. Most of the service providers' skipped enquiries on breastfeeding status of the client except for two of the facilities where the clients were asked about their breastfeeding status, issues regarding living with spouse and desire to have more children were disregarded by the service providers.

  The staff directly enquire from the clients what brought them to the hospital and once they mentioned family planning the next question was what type of method they desired without any counselling; providers only instruct the clients to carry out some investigations like urine testing, blood pressure monitoring and weighing, explanation is only done on urine testing result while medical history to know whether a client is eligible for a particular method was neglected in five of the facilities visited.

IEC materials for counselling were not been utilized in all the hospital despite been placed on the wall except for one hospital that were able to display all the available IEC material for clients to make their choice. Demonstration of how to use the selected method was carried out by the health care providers but issues regarding side effect were disregarded during the counselling process.

- ✓ **Inform choice**: the clients are allowed to make their choice without interference from the service providers for majority of them have already decided with their spouse what method to choose.
- ✓ **Information on follow-up/referral**: referral has not been observed in four out of the seven hospitals under study; some of the hospital advised the clients to come back when stock are available. Follow-up information was given in all of the hospital except that most of the clients interviewed verbalized that they usually use previous prescription to obtain and treat themselves.

Table 4.3Distribution of Contraceptive Method Mix Offered from August 2017 toJanuary 2018

Method	GH B/magaji	GHShinkafi	GHBungudu	ASYB Specialist hosp.	GH Tsafe	GHGummi	GH T/mafara	Total	%
Pills	22	83	38	90	180	90	79	582	14.57
Tubal ligation	0	0	0	0	0	0	1	1	0.03
Injectables	42	68	212	893	448	224	101	1978	49.52
Vasectomy	0	0	0	0	0	0	0	0	0.0
IUCD	0	0	1	4	17	2	0	24	0.60
Implant	0	0	42	179	702	241	223	1387	34.73
Diaphragm	0	0	0	0	0	0	0	0	0.0
Condom	3	12	0	7	0	0	0	22	0.55
Total	47	173	293	1173	1347	557	404	3994	100

Source of Data: Hospital Service Delivery Registers

Table 4.3shows the availability of contraceptive. Injectable has the highest % of 49.52, followed by Implant with 34.73%, pills with 14.57%, while IUCD has 0.60%.

Table 4.4Distribution ofClient's Satisfaction with Counseling Services Rendered

Variables	Satisfactory		Not Satisfied	
	Freq.	%	Freq.	%
Perception of waiting time	39	81	9	19
Cost of service provided	46	96	2	4
Counselling session	31	65	17	35
Easy access to services	35	73	17	27
Method choice and availability	35	73	13	27

Table 4.4above shows that clients were satisfied with all variables presentedexcept for waiting time before and during consultation with 9% clients complaining of staying for an hour before consultation.

4.3.6 Findings from qualitative study for client's satisfaction shows that clients were a bit concerned about the waiting time as reported below;

> "If the time for consultation can be reduced it will be appreciated, because nobody wants to waste his time seeing doctor".

4.3.6.1 Cost of service: which include transportation, cost for contraceptives and service fee was not a hindrance to client's as mentioned by most of them;

> *"From my house to the hospital is not far, the contraceptives are free but some service fee was demanded from some of us that selected Implant and IUCD",*

4.3.6.1 When asked about satisfaction with information received in the clinic during their visit, utilization of the clinic in the near future due to easy access and recommending the facility to others due to availability of method choice, some of the client lamented that;

> *"We are satisfied with the information received from the service provider",*
>
> *"do I have an option, is the only largest public health care facility in the local government and the only one accessible to me", "yes I can encourage my neighbour, relatives, co-wives or anybody that reveal her problems to me to come to this hospital because am happy with the way things were explained to me and am satisfied".*

4.3.7 Follow-up appointment:Some of the client's verbalized during interview that;

> *"The service provider usually informed us to come back for any side effect or complications, when it does happen they will prescribe some medicine for us and sometimes if we complain about bleeding, they will tell us to go back home it will cease".*

But a client mentioned that

> *"I normally use my previous prescription for any health related complications when it occurs so I don't usually come back for any follow-up despite been told to do so".*

Table 4.5 Intercorrelation between Socio-Demographic Characteristics of the Respondents (Women) and Client Satisfaction

Variables	Perception of waiting time		Cost of service provided		Counselling session		Easy access to services		Method choice and availability	
	S	NS	S	NS	S	NS	S	NS	S	NS
Age										
10-14 years	5	2	7	0	4	3	5	2	6	1
15 -19 years	10	2	10	2	4	8	8	4	10	2
20-29 years	14	2	16	0	12	4	10	6	13	3
30-39 years	5	3	8	0	6	2	5	3	3	5
40 years and above	5	0	5	0	5	0	3	2	3	2
Test statistic	p=0.421		p=0.180		p=0.057		p=0.992		p=0.121	
Level of education										
Non-formal	17	1	16	2	14	4	11	7	13	5
Primary	7	4	11	0	8	3	9	2	7	4
Secondary	8	2	10	0	6	4	5	5	7	3
Tertiary	7	2	9	0	3	6	6	3	8	1
Test statistic	p=0.223		p=0.324		p=0.131		p=0.481		p=0.639	
Occupation										
Civil servant	11	3	14	0	5	9	9	5	11	3
Unemployed	14	4	18	0	12	6	11	7	12	6
House wife	14	2	14	2	14	2	11	5	12	4
Test statistic	p=0.734		p=0.124		**p=0.012***		p=0.897		p=0.734	
Religion										
Islam	30	6	34	2	24	12	24	12	26	10
Christianity	8	2	10	0	6	4	5	5	7	3
Others	1	1	2	0	1	1	2	0	2	0
Test statistic	p=0.498		p=0.706		p=0.841		p=0.351		p=0.672	
Parity										
1-3	9	3	12	0	8	4	11	1	8	4
4 – 6	14	5	17	2	16	3	12	7	14	5
7 – 10	8	0	8	0	4	4	4	4	5	3
11 and above	8	1	9	0	3	6	4	5	8	1
Test statistic	p=0.360		p=0.364		**p=0.050***		p=0.102		p=0.605	

S – satisfactory, NS – Not satisfactory *significant

Table 4.5 shows the intercorrelationbetween five subsets of socio-demographic characteristics of the respondents (women) and five subsets of client satisfaction with counselling.Constructs correlation was computed using Pearson correlation in order to examine the relationship between the variables. The subsets of occupation and parity are found to be significantly correlated with counselling session (p=0.012 and p=0.050) respectively but not significant with perception of waiting time (p=0.734) (p=0.360), cost of service provided (p=0.124) (0.364), easy access to service (0.897) (0.102), and method choice (0.734) (0.605) respectively. Age, level of education, and religion were not correlated with all the subsets of client's satisfaction.

4.6 Summary of Findings

The result of this study supports the concept of promoting improvement in the delivery of quality in contraceptives. Client-provider interaction was poor as observed by the researcher and reported by client during client exit interview, IEC materials were only displayed in one of the sampled hospital with all other staff in the sampled hospital explaining verbally despite having the posters pasted on the walls.Assessment of clients was not performed, history taken and investigation were limited to urine testing, blood pressure monitoring and weighing while the environment in the hospitals did not provide adequate opportunity for the clients due to lack of enough privacy. Shortage of service providers was observed as narrated by the heads of the sampled public health care facilities. All surveyed hospital provided a minimum of four (4) method i.e. injectables, Implant, Pills and Intrauterine Contraceptive Device (IUCD), though most of the clients reported that they received the method of their choice, but an adequate number of different family planning methods were not available. Client satisfaction with service provided was satisfactory, but many reported fear of developing health problem from use of family planning as issues relating to side effect was not adequately discussed.

CHAPTER FIVE

5.0 DISSUSSION

The study was aimed at assessing quality of contraceptive counseling services in public health care facilities of Zamfara state. In this chapter the results were discussed following the headings used in the literature review; formally/certified family planning service providers, quality of contraceptive counseling, number of clients offered with contraceptive method mix six months preceding the study, and clients satisfaction with contraceptive counseling.

Findings of the study revealed that most of the clients are within the reproductive age 20-39 years which are fertile years for women of reproductive age group as stated by World Health Organization (WHO, 2009). All the respondents were married. This is probably because the area of study is Northern Nigeria which is predominantly occupied by Hausas' who believe in becoming pregnant within culturally legitimate marriage and believes in polygamous type of home, so for that women are the majority who practice family planning.

The findings on respondents level of education indicate that most of the respondents had no formal education, this is probably due to the culture of the study area of not valuing a girl`s child education, the finding is synonymous to the findings of Wall (1998) as cited in (Nangendo, 2012), who identified a combination of factors that obstruct contraceptive knowledge, adoption, and utilization among Hausa women in northern Nigeria. He asserted that few Hausa women have any knowledge of birth control and they consider family planning as the moral agnate of murder. The findings on occupation revealed that few of the respondents were civil servants, this is similar with a study conducted by (Eze and Hope, 2014) in Adankolo town of kogi state

Nigeria, were he mentioned that women have seen the need for birth control but cultural, religious and gender factors still obstruct full implementation even among the literates.

On religious belief of the respondents, majority of them practice Islam, this is because the study area is dominated by Hausas` who are mainly Muslims, the findings is in agreement with a study conducted by Ejambi, Dahiru and Aliyu (2015) on Utilization of modern contraceptives in the northern zones of Nigeria, The study revealed that northern regions of the country are populated predominantly by Muslims, who have a more conservative culture. The findings on parity shows that women with 4-6 children are the majority, this is synonymous with Omu (2006) who asserted that 71% of high parity women in Nigeria are using family planning and a report by (NDHS, 2018) who mentioned that modern contraceptive use is higher among currently married women with 3-4 living children (15%)than among those with 1-2 living children (11%)

Findings of this study demonstrated that the number of formally/certified trained FP service providers is in short fall, none of the providers have comprehensively trained for six weeks in all the methods of family planning, which is the standard. Almost all the providers were trained for maximum of two weeks or less in one or all aspect of family planning methods but mostly on Long Acting Reversible Contraceptive (LARCs) by Non-Governmental Organization (NGOs), this finding is in support of a report by Nigeria family planning blueprint, (2014) which stated that there is a major shortage of skilled providers for delivering family planning services, especially for injectables. In most of the hospital visited no physician participate in family planningactivities as mentioned by the heads of the sampled public health care facilities except when decisions are made during surgery to perform surgical methodsmostly Bilateral Tubal Ligation (BTL) for women due to complications.The total number of

service providers in all the health care facilities was 34with Community Health Extension Worker (CHEW) constituting a minimum of 2.9% unlike other places where they are the majority. This finding is not in congruence with a report by Nigeria family planning blueprint(2014) which asserted thatin the North, Nigerians rely on CHEWs as the primary point of care. They often work as the only staff members of PHCs, providing all the care in the community and sometimes delivering services for which they are not properly trained. Human resource density according to (Nigeria family planning blueprint, 2014) shows a low density of health care providers in Zamfara state with nurses/midwives accounting for 252 and CHEW 500 as supported by the findings of this study. There is therefore the need for in-service training of providers to improve their skills in providing quality counselling, management of side effects and complications.

Though most women reported during interview that they were treatedwith respect and health care providers were friendly, greetings was only initiated by the clients except for one hospital were the provider greeted the client before initiating group counselling'

This finding is in agreement with a study by Williams and Schutt-Aine,(2008) who affirmed that from a human welfare perspective, all clients, no matter how poor, deserve courteous treatment from service providers and women are more likely to seek out and continue using family planning services if they receive respectful and friendly treatment (Vera 1993; Ndhlovu 1995; Kenny 1995, as cited in Stein 1998; Williams et al. 2000 as cited in Creel, Sass and Yinger, 2015).

In many societies, courtesy is a sign that the client is regarded as the provider's equal. To provide quality counselling to family planning clients, facilities should be able to provide some level of privacy, family planning is often a sensitive issue for discussion. Providing counselling where clients can be reasonably assured that the conversation is

not overheard improves communication and ultimately the likelihood that method provided to clients is suitable. When clients were asked about privacy, they stated that no one overheard their discussion, but still they prefer to visit on days devoid of antenatal care as lamented by the client‘s below;

> *“Yes I don’t think there is anyone that overheard our discussion today but if it was on antenatal clinic days because of too many women there is a tendency that others might hear what is been discussed, so that is why I prefer to come on a day like this where there are few women”.*

Thisfinding is in agreement with Halpern, Lopez, Grimes and Gallo, (2011) who mentioned that it is the right of the clients to be treated with privacy and dignity.

During a client’s visit, providers are expected to elicit relevant personal and health history that will provide the information they need in assisting client‘s to make an informed choice. Findings on assessment of both new and returning clients receiving family planning in all the sampled public health care facilities were skipped by the service providers; this may result into wrong choice of method to a client. Most of the client‘s interviewed reported not been asked any question relating to use of any contraceptive method before, this finding is supporting a study by Okullo and Okello(2003) who assert that poor client-provider interaction can lead to clients not having essential information to choose an appropriate method; not getting the method they want; not learning what they need to know about how to use the method or how to cope with side effects; not being aware that they can switch methods if their current one is unsatisfactory; not being satisfied with their method; and ultimately, not achieving their fertility goals, due to contraceptive failure or discontinuation.

Knowing a client‘s breastfeeding status is essential in determining a suitable method of contraceptives, interviews conducted indicated that most of the clients were not asked about their breastfeeding status.Likewise providers rarely ask about client‘s husband attitude towards family planning or other factors such as if the client has interest in having more children in near future and whether she is staying with her husband, this is because decisions to select a method was made by both the women and their husbandsas most of them verbalized during interview;

> *“The service provider has already seen us with our babies, she knew that we are breastfeeding mothers therefore, she didn‘t bother asking and we were also not asked on the need for more children in the near future”.*

> *“No, the service provider didn‘t ask me any question on whether I have use any method previously or my husband attitude towards family planning because I have already told her that I and my partner have already discussed at home on what method to select so she assumes he already knew”.*

Questions relating to medical conditions of the clients were not asked by most of the service providers as evidenced by client‘s statement during interview;

> *“The only investigations carried out were urine testing to exclude pregnancy status, weighing and blood pressure measurement, but as per explanation of the result, they assume we know so it was not done, issues regarding STIs, hypertension, diabetes and other medical conditions were not discussed”.*

Medical condition of the clients is a pre-requisite for use of any family planning method to prevent complications and enhanced continuity.

Effective communication is essential to help family planning clients make informed decisions when they are faced with choosing between multiple contraceptive methods. However, family planning clients are frequently passive in communicating their needs and preferences (Kim, 2011 as cited in Halpern, Lopez, Grimes and Gallo, 2011).

Findings on counselling revealed that explanation on how the selected methods works were not fully explained to the clients as testified by one of the clients during client exit interview;

> *"The service provider just asked us what method we like and when we mentioned she gave it to us.*

This finding is not in agreement with Langston (2010) as cited in Halpern, Lopez, Grimes and Gallo (2011)who mention that some approaches to counselling might be more effective than others. For instance, structured counselling by use of audio and visual materials with standardised information has been designed to prevent unintended pregnancy. But in agreement with a report by Askew, Mensch and Adewuyi (2016) who assert that in most of the Service Delivery Points (SDPs), few Information Education and Communication (IEC) aids were used and group health talk were a common method of imparting information.

When asked whether they were influenced to choose a method, the client's expressed that the service providers were non-judgemental in method selection, this finding is similar with a study finding which assert that quality counselling 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, (ACQUIRE Project, 2008). The clients interviewed lamented that issues regarding contraceptive benefits, advantages, disadvantages and side effects were not fully explained during the counselling process, the only side effect mentioned mostly was bleeding;

> *"The service provider didn't tell me anything in respect to how the method I selected works, she only told me when to come back for the next visit, for the side effect she only mentioned bleeding"*

This finding is not in agreement with study findings by Stanback, Steiner, Dorflinger, Solo and Willard, (2015)who suggested that the information provided to people so that they can make an informed choice about contraception should emphasize the advantages and disadvantages, the health benefits, risks and side-effects, and should enable comparison of various contraceptive methods. But the finding is in support of a study by Askew, Mensch and Adewuyi, (2016) who stated that in most of the sub-Saharan Africa, Nigeria inclusive, quality of contraceptive counselling services still remain low and unmet need of family planning remains high, equal amounts of information on each method during counselling were not provided, limited information was provided on how to use, side effects, effectiveness and contraindications.

Client's expression on toilets facilities was positive as they claimed not to have visited the toilet throughout their stay in the hospital. The finding was similar with study findings by Halpern, Lopez, Grimes and Gallo, (2011) who state that quality of counseling should reflect interpersonal processes of care such as clinic inventory, cleanliness, adequate spacing, adequate seating, shelter and a survey reported by (Khadka and Amin, 2015) which revealed that most of the facilities had adequate light source, availability of water and soap, separate room for counseling. All the facilities

had separate room for clinical examination and procedure and a few facilities had separate toilet for clients and staff and separate instrument processing room and autoclaving area. Clients responses in regards to infection prevention and control was poor, this finding is in support of a survey by Achyut, Nanda, Khan and Verma, (2015) who highlighted that items for infection control are available in the family planning service area in less than one third of facilities, with soap and running water being the items most commonly lacking.

Observation made during the period of data collection revealed that manner of greeting in all the public health care facilities visited was the same, with the clients greeting the health care providers first, the reason been a norm in Hausa culture to initiate greeting whenever a person visited somebody, except for one health care facility where the service provider greeted the clients before initiating group counselling. Most of the observed family planning counselling sessions were conducted under conditions where there is no separate room for counselling process; this is carried out in the antenatal clinics or nurses' station of the labour ward with only one hospital having a waiting space and examination room separate from the space provided for antenatal care services.

Information regarding client breastfeeding status, client's husband attitude towards family planning or other factors such as if the client has interest in having more children in near future and whether she is staying with her husband were not asked by the service providers as evaluated by the researcher during counselling sessions in all the hospitals except for two of the facilities where the clients were asked about their breastfeeding status.There was no evidencein all the facilities that physical examination was carried out; the only investigations carried out were urine testing to exclude pregnancy, blood pressure and weighing. Use of IEC materials duringcounselling

sessions to explain chosen methods to the clients was carried out by only one public health care facility; however even at this facility full explanation of the method chosen was given in sceptical. Service providers were observed not to be bias to clients in selecting their method of choiceandpractice of infection prevention and control was not done except for one hospital that has a designated area for that purpose; however the practice was also poor as observed by the researcher.

A high degree of consistency and commonality were recognized between the information gotten during CEI and observation made by the researcher. The homogeneity of the information has enhanced the credibility, dependability, conformability and reinforcement of the study findings.

A facility that offers all methods of family planning is best able to meet up the needs of the clients. Availability of family planning methods are associated with adoption, continuation and switching of contraceptive methods,as high concentration of contraceptive use on one or two methods may be a sign of a limited range of available methods (Biddlecom and Kantorova, 2013). Findings of this study demonstrated that almost 4000 women of reproductive age group patronized family planning services in the study area which clearly depicted increased awareness on the benefit and need for family planning among women and remarkable for the state as low patronage of Family Planning (FP) services have been reported by several studies in the study area. Family planning method mix varies across the public hospitals visited during the period of data collection. Injectables, Implant, pills and Intrauterine Contraceptive Device (IUCD), were available in all the sample health care facilities. This revealed a high concentration of only four methods.

The most commonly offered family planning method is injectables, which was probably due to a policy change allowing CHEWs to administer injections and its wide

spread availability, this finding contradicted a study by Bongaarts and Kantorova, (2012) who mentioned that despite rising popularityof Depo-Provera, a three-month injectable it was relatively under-utilized, it has yet to gain the extent of acceptance of the three leading methods (sterilization, the pill, and the IUD) but in agreement with a study report in Bauchi North eastern Nigeria by (United States Agency for International Development (USAID), 2015) which revealed that most of the included facilities under study, injectables were reported as the most preferred method by family planning clients, followed by implants and then oral contraceptives;also the study byMuhammad and Maimuna (2014)stated that in northern Nigeria contraceptive prevalence was 31.6% among women attending antenatal care, the most common method were injectables (noristerate and depo-provera) used by 68% of the client, oral contraceptive accounting for 10.4%, male condom 2.8%, female sterilization 3.4%, IUCD 16.6%, followed by implant contributing 2% only and a recent study reported by NDHS (2018) reported that, the most commonly used modern methods of contraception among currently married women are injectables and implants (3% each).

The finding from this study revealed that one third of the respondents used Implant,the finding is in support of observation made by the researcher during data collection which shows that almost every woman interviewed revealed her interest on Implant and among the main reasons for the heavy reliance on this method as lamented by the respondents was that Implant is less invasive than IUCD, nobody will ever know that one is practising family planning except if told by the user, does not require every day taking like the pills andhas less side effect when it comes to bleeding.

Finding of this study on pill revealed that few of the respondents takes pills as a method of contraception, this is not in agreement with Bongaarts and Kantorova, (2012) as they asserted that for reversible methods, the pill or the IUD often occupy the top position,

with many countries showing strong preference for one over the other. Among the available and most accessible methods as revealed by the study finding, IUCD is the less used contraceptive with 0.60% because women complain of invasiveness of their privacy, discomfort and pelvic pain, whereas condom is seen in only one hospital this revealed a shortage of contraceptive methods in the public facilities.

Decision to perform permanent methods (vasectomy and tubal ligation) are only taken in cases of complications as mentioned by the in-charges, this finding contradicted a study by Bertrand, Rice, Sullivan and Shelton (2010) which shows that on a global basis, the most widely used contraceptive methods are female sterilization, the pill, and the IUD.

Findings on satisfaction revealed that most of the clients interviewedexpressed duration ofwaiting time between arrival and consultations is within two hours, this finding supported a study finding in both Malawi andSenegal, were clients identified long waiting timesas a concern, (Family Planning ServiceExpansion and Technical Support/John Snow,Inc. 2000: 38 as cited in Upadhyay 2001).On perception of waiting time, the clients mentioned that;time for consultation should be reduced as they don't wants to spend much time seeing a doctor. Some of them stated that the waiting time is reasonable except on antenatal days were individual need to spend much time before seeing a service provider".

These findings are synonymous to a study in Kenya by Hutchinson and Agha, (2011) which revealed that clients were satisfied with FP services and had no problems with all of the following: waiting time 93.1%, ability to discuss concerns with provider 97.2%, quality of examination and treatment provided 96.2%, visual privacy during examination 97.1%, auditory privacy during examination 96.7%, availability of the methods at facility 97.6%,cleanliness of facility 99.5% and how the staff deals with the

client 100%. According to government policy, a hospital providing family planning services is to provide it without any fees, there should be no charge for any government contraceptives method administeredin order to increase acceptability.

On cost of service provided,almost half of the respondents were satisfied with the services provided as no money is involved, only few respondents expressed that some service fee is demanded for family planning methods such as Implant and IUCD insertion, this may be for maintenance of items needed for the procedure which the hospitals purchases as they are not been provided by the government, this findings is not in support of a study conducted by Aminu, (2015) who asserted that method related reasons like health concerns, fear of side effects, and lack of access/too far, too much costs and health care provider bias accounted for 32.4% of non-utilizations of family planning services, but in agreements with Nasr and Hassan(2016) whose study showed that, the great majority (99.59%) of clients were satisfied about cost for the family planning methods.

Almost all the respondents expressed satisfaction on information given to them by service providers during their visit to the clinic,

> *"We are satisfied with the information received from the service provider",*
>
> *"Do I have an option, is the only largest public health care facility in the local government and the only one accessible to me".*

This is probably because the clients have no knowledge of what they were supposed to receive because most of the information needed for qualitative counselling were not mentioned by the service provider as observed by the researcher, the finding isnot in consistence with a study carried out by Ayona (2017) who affirmed that clients' satisfaction on utilization of FP service delivery is low with service providers

restricting information on long term contraceptive, limiting methods to hormonal methods, injectable and oral contraceptive pill, prolong waiting time and insufficient information on method of choice, but in support of Hutchinson and Agha (2011) study in Kenya which revealed that92.0% of clients interviewed were satisfied with amount of explanation given in the facilities under study. When the respondents were asked if they will utilize the facility for health care services in the future,more than half said yes, the findings affirmed a report by Hutchinson and Agha (2011) who asserted that around 95.8% of all the clients in their study mentioned that they would return to the health facility for future services.

On recommending the services of the hospital to others due to availability of method choice, three quarter affirmed that they will recommend the services to others;

> *"Yes I can encourage my neighbour, relatives, co-wives or anybody that reveal her problems to me to come to this hospital because am happy with the way things were explained to me and am satisfied".*

The client responses may be due to the fact that the hospital was the only accessible public health centre and not fully been aware of what information to receive during their visit to the hospital. The finding supportedHutchinson and Agha (2011) study which revealed that around 97% of the clients mentioned that they would suggest others to visit the health facility.Referrals for further family planning contraceptives out of stock, family planning related health complications and follow-up are not fully done.

Regarding the correlation of occupation and parity, the finding of the study revealed a positive correlation with counseling session but no significant association was found in respect to age, level of education and religion with the subsets of clients satisfaction.

CHAPTER SIX

SUMMARY, CONCLUSION AND RECOMMENDATIONS

This chapter deals with summary, conclusion, implication for nursing, recommendation, limitation and suggestion for further studies

6.1**SUMMARY**

Family planning is very important and highly beneficial as it plays an important role in reproductive life and protection of maternal health**.**The study was aimed at assessing quality of care for contraceptive counselling services in public health care facilities of Zamfarastate with the objective of identifying number of formally/certified trained family planning service providers, assessing contraceptive counselling services, determining number of client‘s offered contraceptive method mix for last six months preceding conduct of the study and assessing client‘s satisfaction with counselling services provided. A concurrent mixed method study design (qualitative and quantitative) was employed for the study. The qualitative component elicited information on client-provider interaction and client satisfaction with contraceptive services provision while the quantitative component elicited information on contraceptive method mix the last six month prior to survey and the number of trained FP providers in selected facilities. Using a multi-stage sampling technique, seven secondary facilities were selected for the study and 48 clients were interviewed. Qualitative data were collected via observations during counselling sessions and client exit interviews. Service delivery registers of the selected facilities were scrutinized for availability of contraceptive method mix in the last six months prior to survey. The number of formally trained FP providers in the selected facilities was obtained from the

state MCH Coordinator and corroborated at the facilities from the respective head of the FP clinics.

Findings revealed client-provider interaction was poor and trained service providers were in short supply. Nearly 4,000 clients were offered various contraceptive method mix in which the injectable was the commonest method accounting for almost half of these clients followed closely by the implant with 34.73% and despite the negative responses by the clients on quality counselling, respondents were still satisfied with some aspects of counselling such as free contraceptives.

6.2CONCLUSION

Strengthening family planning and improving contraceptive counselling will significantly improvequality of care and better treatment of family planning users subsequently increasing contraceptive prevalence and decline in fertility with an improvement in women‘s reproductive health. This study found that;

There is a shortage of service providers in provision of family planning services in the state, likewise counselling was poor as reported by the client‘s during interview and evaluated by the researcher, this shows the need for change in methods use during counselling to get the desired effect.The number of women patronising FP services in the state is remarkable and injectables is found to occupy three quarter (3/4) of the available methods in the state.Despite the negative responses by client‘s on counselling, clients were still satisfied with some aspect of service provision like free contraceptive and the information they received from their service providers.Therefore, there is need for government to put all measures to increase employment, in-service training, supervision and supply of different methods of contraception.

6.3 RECOMMENDATIONS

The hospital management should upgrade the facilities by;

a. Encouraging in-service training of service providers to become more competent in counselling process.
b. Use of counselling guide in family planning should be encouraged by the management to enhance standard.
c. Reducing clients waiting time, providing a more client friendly environmentand providing adequate IEC materials that will improve quality of service provision.
d. Regular supervision of service providers' toidentify deficiencies.
e. The government should ensure that all family planning methods offered should be available in all the public health care facilities to improve client's method choice.
f. Government should employ more staff in various health care facilities to avoid shortages.
g. Encourage and support nurses to go for workshop and seminars to improve their competences.
h. Provision of separate environment where only family planning services is provided.

6.4 LIMITATION

1. The study only looked at counselling in one part of the country therefore it does not portrait what is obtainable in other places.
2. The sample size was only limited to a small number as it applied to qualitative study, a quantitative study will provide more chance for generalization.

3. Result based on descriptive analysis is week to make a valid conclusion.

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APPENDIX 1

DEPARTMENT OF NURSING SCIENCES, FACULTY OF ALLIED HEALTH SCIENCES, AHMADU BELLO UNIVERSITY, ZARIA

INTERVIEW GUIDE ON ASSESSMENT OF QUALITY OF CARE FOR CONTRACEPTIVE COUNSELLING SERVICES IN PUBLIC HEALTH FACILITIES OF ZAMFARA STATE Phone Number: 07063903228

Dear Respondents,

I am a post graduate student in the Department of Nursing Sciences Ahmadu Bello University Zaria, carrying out research on the above mentioned topic. All information provided will strictly be used for academic purpose and remain highly confidential and anonymous.

Instruction: Please cooperate by answering what best represent your opinion.

Section A: Socio-Demographic Characteristics

Name of facility.....

1. Age in years: 15-19 { } 20-29 { } 30-39 { } 40years and above { }
2. Marital status: Married { } Single { } Divorce { } Separated { }
3. Level of Education: Non-formal { } Primary { } Secondary { } Tertiary { }
4. Occupation: Civil Servant { } Unemployed { } House wife { } others ……...
5. Religion: Islam { } Christianity { } others (Specify)…….
6. Parity: 1-3 { } 4-6 { } 7-10 { } 11 and above { }

Section B: Interview Guide for Counselling Process

Counselling Process
Greetings
How did you feel in respect to the way you were greeted and welcome by the service provider?
What is your opinion about how the service provider addressed you?
When meeting with the provider during your visit, do you think other clients could see you?
When meeting with the provider during your visit, do you think other clients could hear what you and the provider discussed?
Do you believe that the information that you shared about yourself with the provider will be kept confidential?
Assessment
Can you tell me about the way you were asked if you have used family planning before?
How did the service provider approach you about your interest in using any particular family planning method?
Can you tell me about the way you were asked in respect to your breastfeeding status?
Can you tell me how the service provider approaches you in regards to having more children in feature?
History
What is your opinion on how physical examination was conducted by the service

provider?

Were you asked to carry out any form of investigation?

What is your opinion on how the service provider explained the result of your investigation?

Can you tell me how the service provider confronts you when s/he was asking you about your medical condition?

Information Giving/Client-Provider Interaction

What is your opinion in regards to how the service provider communicates to you?

Can you tell me whether the service provider has display all the available methods?

Were you influenced to choose a method by the service provider? If yes how?

Were you given your method of choice? If not, what was the main reason?

Can you tell me how you choose your method of choice?

Can you tell me how the service provider explained the choosing method?

What is your opinion about the service provider explanations on;

- How the method you choose works?
- Advantages and disadvantages of the choosing method?
- Side effects of the choosing method?

Environment

What is your opinion about the clinic in respect to;

- Counselling/consultation
- Examination room
- Waiting/seating space
- Toilet facility

Clients‘ Satisfaction

Do you feel that your waiting time was reasonable or too long?

Were you ask to pay for service provided to you during your visit today?

Were you satisfied about the information given to you during your visit today?

Will you use this facility for health care services in the future?

What is your opinion in regards to recommending this service to another person?

Follow-up appointment

What can you say about the service provider explanations in regards to follow-up?

Adopted and modified from Young Mi Kim, (1995)

APPENDIX 11

Section A: Observation Guide for Counselling Session

Name of facility.....

Key: Yes=Y, Not Done=ND

S/NO	Counselling Session	Y	ND
1	**Greeting**		
a	Welcoming gestures		
b	Respectful form of address		
c	Privacy		
2	**Assessment**		
a	Enquiry on use of any contraceptive method before		
b	Enquiry on breastfeeding		
c	Enquiry on living with spouse pattern		
d	Enquiry on desire to have more children		
e	Enquiry on knowledge and attitudes toward modern family planning		
f	Enquiry on spouse/partner's attitude toward using a family planning method?		
g	Client decision in choice of FP method		
3	**History**		
a	Enquiry on physical examination		
b	Did provider wash/use sanitizer before physical		

c	examination
d	Enquiry on investigations
e	Proper explanation of investigation result
f	Medical history
4	**Information Giving/Client-Provider Interaction**
a	Good interpersonal communication
b	Use of counselling aids/IEC material
c	Impartial when presenting methods
d	Denial of chosen method by health care provider
e	Provision of reason for denial of a particular method
f	Demonstration of how to use the selected method
g	Explanation of side effect and its management
h	Discuss warning signs and its management
i	Paraphrasing of instruction by client
5	**Follow-up appointment**
a	Instruction on follow-up appointment
b	Instruction on return visit before the due date, when need arise
c	Referral for further FP services
D	Referral for other health services

General observation:

Adopted and modified from Young Mi Kim, (1995)

Section B: Observation Checklist for Method Mix in Contraceptive Utilization from January to June 2017

Name of facility.....

S/NO	METHOD	FREQUENCY	%
1	Pill		
2	Tubal ligation		
3	Injectable		
4	Vasectomy		
5	Intrauterine Device (IUD)		
6	Norplant		
7	Diaphragm		
8	Condom		
	TOTAL		

Section C: Observation Checklist for Client`s Satisfaction with Counselling Services Rendered

Variables	Satisfactory		Not Satisfactory	
	Freq.	%	Freq.	%
Perception of waiting time				
Cost of service provided				
Counselling session				
Easy access to services				
Method choice and availability				

PARTICIPANT INFORMATION

Title of the study

Assessment of Quality of Contraceptive Counselling Services in Public Health Facilities of Zamfara State, Nigeria

To participant in this study

I invite you to be part in this research that could improve your quality of care as women in contraceptive services. Below is a brief description of what this research could entail for you. Feel free to seek clarification of issues and demand further explanation of proceedings**.**

You are at liberty to refuse participation. You may withdraw from the research at any time and for any reason.

What is the purpose of the study?

The reason for conducting this study is to assess the quality of care of contraceptive services in public health facilities in Zamfara state, Nigeria. The information gathered from this study will be used to develop recommendations to reproductive health managers, policy makers and service providers working in family planning clinics of public health facilities in relation to quality of care.

Do I have to take part?

It is entirely up to you to decide to take part in this study. There are no penalties for refusing to participate.

Your role is simply answering questions from checklist adopted and modified by the researcher after counselling sessions, this will be audiotape, you will also be observed during the counselling session between you and the service provider.

What will happen if I take part?

Your view on checklist and service providers‘ displayed skills will be analyzed using a computer by the researcher.

No identity of yours will be required while filling the questionnaire or during observation.

Incentives

There are no expenses or payments.

Are there any risks in taking part?

The precautions taken with the information gathered at the setting for the observation and other aspects of the study design have been closely considered so as to limit effect of participation in this study. If however your participation causes you some inconveniencies or disadvantage, do not hesitate to inform the researcher either in person or in writing.

What if I am unhappy or if there is a problem?

If you are unhappy or if there is a problem, please contact the researcher (Amina Ahmad on 07063903228/08058666446) or ahmadamina89@gmail.com to lodge your complain.

What will happen to the results of the study?

The results of this research will be presented to Department of Nursing Sciences for the award of Master's Degree in Nursing Sciences by the Ahmadu Bello University,Zaria which will be published by the university and will be available in the postgraduate school library and department of nursing science library. Participants in this research will however not be identifiable in the results.

Informed consent Form

1. I confirm that I have read and have understood the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. □
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my rights being affected. □
3. I accept that taking part in study observation is voluntary and confirm that no risk is associated with this. □
4. I agree to take part in the above study. . □
5. I agree to take part in the observation... □

All the terms of this consent have been explained to me in a language that I understand. I am also aware that strict confidentiality will be maintained in this study.

Signature/Thumb print……